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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

Lori A. Weaver
Interim Commissioner

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Henry D. Lipman
Director

May 31, 2023

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$1,209,229,580 from \$4,718,828,874 to \$5,928,058,454 (for the period since contract inception September 2019), with no change to the completion date of August 31, 2024, and effective July 1, 2023, subject to Governor and Council approval. All terms and conditions of the contract and prior amendment not inconsistent with this Amendment remain in full force and effect. The federal fund share comprises 67.47% of the price limitation increase, the other non-federal fund share is 15.69%, and the general fund is 16.84% from the previous Amendment.

Funding sources are as follows:

	Federal	Other / Agency Income	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	65.4%	1.4%	33.2%
Standard Medicaid Population (Medicaid Care Management)	50.9%	22.6%	26.5%

NOTE New Hampshire is eligible for phase-down of the enhanced Federal Medical Assistance Percentage (FMAP) 2.5 percentage points through September 2023; and 1.5 percentage points through December 2023).

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020 (Item #6), January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), as

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amended on December 08, 2021 (Item #6-1), as amended on June 15, 2022 (Item # Tabled Item 20A), and as amended on December 21, 2022 (Item #13A).

Funds are available in the accounts outlined in the attached fiscal details and are anticipated to be available in the State Fiscal Year (SFY) 2024 and 2025, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

The Centers for Medicare & Medicaid Services (CMS) requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments; however, the Department has received authorization from CMS for the 14-month rating period and related costs in these Amendment #10 contracts given the end of the MCOs' contract terms scheduled to expire August 31, 2024. During typical rating cycles, rates are updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2024 and two months of SFY2025.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request covers the rating period of July 1, 2023 through August 31, 2024. The methodology used to develop the previous Amendment #9 SFY 2023 capitation rates is largely consistent with the capitation rate methodology in this Amendment #10.

With the end of Continuous Coverage as of March 31, 2023 and the federal Public Health Emergency (PHE) on May 11, 2023, the full 6.2% enhanced Federal Medical Assistance Percentage (FMAP) received under the Families First Coronavirus Response Act available to states like New Hampshire has ended as of March 31, 2023. New Hampshire is eligible for phase-down of the enhanced Federal Medical Assistance Percentage (FMAP) 2.5 percentage points April through September 2023; and 1.5 percentage points October through December 2023.

Coinciding with the end of continuous coverage, enrollment is expected to be lower in the 14-month rating period compared to SFY 2023. As of March 31, 2023 just over 103,000 enrollees were protected from redeterminations of eligibility due to continuous enrollment coverage. Full regular eligibility operations commenced effective April 1, 2023. As of May 29, 2021 Medicaid enrollment stood at 210,074, down from the peak of 251,357 at the end of March 2023.

For Amendment #10 relative to the rates, key changes include:

1. The Rate Year (RY) 2024 MCM capitation rates cover the July 1, 2023 through August 31, 2024 period to accommodate the start of a new MCO contract that will be effective September 1, 2024.
2. Capitation rates include a preliminary acuity adjustment increase due to the enrollment mix changes based on the Department's unwind process, and will be updated in Amendment #11 capitation rates based on experience. Specifically, a greater number of lower acuity individuals are expected to become ineligible as compared to higher acuity people. The Department anticipates about 80% of Medicaid protected enrollees will have gone through the redetermination unwind process by October 1, 2023.

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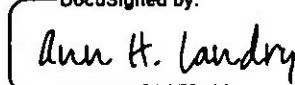
3. The increase cited above in the capitation rate is, however, offset entirely by the updated base encounter data in Standard Medicaid and GAHCP. Specifically, the transition from CY 2019 to SFY 2022 MCO encounter base experience data, and inclusion of non-CMHC encounter data for the GAHCP population enrolled in a behavioral health rate cell, so as not to reduce funding supporting CMHC workforce availability and beneficiary access.
4. The RY 2024 capitation rates include directed payments to community mental health centers (CMHCs), critical access hospitals (CAHs), state-owned hospitals for professional psychiatric services, and children's hospitals (subject to CMS approval); these amounts are included in the MCO capitation rates. MCOs are not at-risk for the amount of these directed payments. Per member cost increases outlined in Table 2 for the directed payment to CAHs is largely a function of the pool of dollars spread over the lower enrollment expected in RY 2024.
5. An overall 7.7% administrative cost allowance for the Standard Medicaid population, an increase by 0.1% from Amendment #9, and 8.6% for the GAHCP population; an increase of 0.2%; however, the total spending for administrative costs is projected to decline from \$8.7 million a month in SFY 2023 to \$6.8 million a month in RY 2024 under this amendment.
6. In RY 2024, the MCOs' targeted medical loss ratio (MLR) for at-risk services of 90.8% for the Standard Medicaid population and 89.9% for the GAHCP population are based on projected enrollment distribution for the rating period; a 1.5% risk margin is applied as a percentage of revenue prior to the directed payments and the 2% premium tax allowance; and includes a continuation of the risk corridor.

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Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session. The current GAHCP is subject to a reauthorization as of December 31, 2023. Both the House and Senate have legislation to reauthorize, though for different lengths of time.

Respectfully submitted,

DocuSigned by:

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Lori A. Weaver

Interim Commissioner

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APPENDIX

Table 1A below shows the statewide rate change by population from the Amendment #9 SFY 2023 capitation rates to the Amendment #10 RY 2024 rates, excluding directed payments, using current RY 2024 population estimates provided by DHHS.

Table 1A New Hampshire Department of Health and Human Services Medicaid Care Management Program RY 2024 Capitation Rate Change Based on Projected RY 2024 Enrollment by Rate Cell Excluding Directed Payments			
Population	Amendment #9 SFY 2023	Amendment #10 RY 2024	Rate Change
Standard Medicaid			
Base Population	\$363.62	\$374.67	3.0%
CHIP	232.80	227.44	-2.3%
Behavioral Health Population	1,456.15	1,390.67	-4.5%
Total Standard Medicaid	\$427.60	\$430.73	0.7%
Granite Advantage Health Care Program			
Medically Frail	\$1,074.95	\$1,051.49	-2.2%
Non-Medically Frail	414.34	454.27	9.6%
Behavioral Health Population	2,010.41	1,920.66	-4.5%
Total GAHCP	\$568.13	\$592.88	4.4%
Grand Total	\$473.92	\$484.17	2.2%

Table 1B below shows the statewide rate change by population from the SFY 2023 capitation rates to the RY 2024 rates, including directed payments.

Table 1B New Hampshire Department of Health and Human Services Medicaid Care Management Program RY 2024 Capitation Rate Change Based on Projected RY 2024 Enrollment by Rate Cell Including Directed Payments			
Population	Amendment #9 SFY 2023	Amendment #10 RY 2024	Rate Change
Standard Medicaid			
Base Population	\$375.37	\$389.84	3.9%
CHIP	238.53	236.01	-1.1%
Behavioral Health Population	1,507.71	1,451.59	-3.7%
Total Standard Medicaid	\$441.52	\$448.43	1.6%
Granite Advantage Health Care Program			
Medically Frail	\$1,113.50	\$1,106.91	-0.6%
Non-Medically Frail	423.65	483.31	14.1%
Behavioral Health Population	2,045.37	2,004.32	-2.0%
Total GAHCP	\$582.04	\$627.46	7.8%
Grand Total	\$487.83	\$507.44	4.0%

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Table 2 shows a breakdown of the capitation rate changes by major rate component for the RY 2024 capitation rates compared to the SFY 2023 capitation rates on a percentage and aggregate dollar basis. Please note, the various rate change components include the impact of attributed administrative allowance, risk/profit margin and premium tax beyond the service costs alone.

Table 2 New Hampshire Department of Health and Human Services RY 2024 MCM Capitation Rate Change by Component¹ Based on Projected RY 2024 Enrollment by Rate Cell						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	14-Month Dollar Impact	Rate Change	14-Month Dollar Impact	Rate Change	14-Month Dollar Impact
Assumption Changes						
Administrative Allowance	0.44%	\$3,220,106	0.51%	\$2,424,415	0.46%	\$5,644,521
Durable Medical Equipment "Lesser of Logic" Adjustment	0.04%	278,840	0.02%	109,119	0.03%	387,959
Pharmacy Efficiency Savings	-0.30%	(2,205,421)	-0.52%	(2,513,724)	-0.39%	(4,719,145)
Preliminary Acuity Assumption	3.75%	27,753,850	8.20%	39,316,015	5.50%	67,069,865
Hospital Outpatient Cost to Charge Ratio Adjustment	0.71%	5,250,415	1.05%	5,045,704	0.84%	10,296,119
Applied Behavioral Analysis Trends	0.57%	4,251,192	0.00%	4,412	0.35%	4,255,604
Pharmacy Trends (including Preferred Drug List and Rebate Changes)	-0.36%	(2,645,817)	-0.67%	(3,196,102)	-0.48%	(5,841,919)
Utilization Trends	1.44%	10,620,911	1.57%	7,536,848	1.49%	18,157,759
Unit Cost Trends	0.37%	2,725,939	0.57%	2,712,625	0.45%	5,438,564
Boston Children's Hospital Risk Pool	0.36%	2,651,220	0.06%	286,003	0.24%	2,937,223
Impact of Granite Advantage Behavioral Health Population Non-CMHC Experience	-1.37%	(10,140,829)	-2.60%	(12,468,506)	-1.85%	(22,609,335)
Base Data and Other	-4.94%	(36,527,649)	-3.93%	(18,867,778)	-4.54%	(55,395,428)
Total Assumption Changes²	0.71%	\$5,232,757	4.25%	\$20,389,030	2.10%	\$25,621,787
Directed Payments						
Children's Hospital Directed Payment	0.11%	797,291	0.00%	23,011	0.07%	820,302
State Owned Hospital Professional Services Directed Payment	0.13%	994,998	0.08%	388,011	0.11%	1,383,010
CMHC Directed Payment	0.04%	273,575	0.13%	616,522	0.07%	890,097
Critical Access Hospital Directed Payment	0.58%	4,284,773	3.34%	16,000,055	1.66%	20,284,828
Total Directed Payment Changes	0.86%	\$6,350,637	3.55%	\$17,027,600	1.92%	\$23,378,237
Total Changes	1.57%	\$11,583,394	7.80%	\$37,416,630	4.02%	\$49,000,024

¹ The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.

² Differences from Table 1A results are due to rounding and the order in which the rate changes are calculated.

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**Medicaid Care Management Services Contract
Amendment #10 Fiscal Details**

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND					
State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	\$575,768,481		\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	\$624,392,133		\$624,392,133
SFY 2024	101-500729	Medical Payments to Providers	\$0	\$400,697,542	\$400,697,542
SFY 2025	101-500729	Medical Payments to Providers	\$0	\$66,782,924	\$66,782,924
		<i>Sub-Total</i>	\$2,042,339,166	\$467,480,466	\$2,509,819,632
05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION MEDICAID SERVICES, OFC OF MEDICAID SERVICES CHILD HEALTH INSURANCE PROGRAM					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$102,351,504		\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	\$118,376,791		\$118,376,791
SFY 2024	101-500729	Medical Payments to Providers	\$0.00	\$101,823,220	\$101,823,220
SFY 2025	101-500729	Medical Payments to Providers	\$0.00	\$16,856,638	\$16,856,638
		<i>Sub-Total</i>	\$339,602,654	\$118,679,858	\$458,282,512
05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$618,433,737		\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	\$630,266,172		\$630,266,172
SFY 2024	101-500729	Medical Payments to Providers	\$0.00	\$534,571,903	\$534,571,903
SFY 2025	101-500729	Medical Payments to Providers	\$0.00	\$88,497,353	\$88,497,353
		<i>Sub-Total</i>	\$2,336,887,054	\$623,069,256	\$2,959,956,310
		Total Funds	\$4,718,828,874	\$1,209,229,580	\$5,928,058,454



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Denis Goulet
Commissioner

June 1, 2023

Lori A. Weaver
Interim Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Interim Commissioner Weaver:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, as described below and referenced as DoIT No. 2019-005J.

These amendments refresh the actuarial rates to cover program costs. The price limitation with the vendors listed above will increase to continue providing health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management.

The Price Limitation will increase by \$1,209,229,580 from '\$4,718,828,874 to \$5,928,058,454 with no change to the completion date of August 31, 2024 effective July 1, 2023 or upon Governor and Council approval, whichever is later.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/ik
DoIT #2016-105J
cc: Michael Williams, IT Manager, DoIT

**State of New Hampshire
Department of Health and Human Services
Amendment #10 to the Medicaid Care Management Services Contract**

This 10th Amendment to the Medicaid Care Management Services contract (hereinafter referred to as "Amendment #10") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and AmeriHealth Caritas New Hampshire Inc.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on March 27, 2019, (Tabled Late Item A), as amended on April 17, 2019 (Item #9), as amended on December 18, 2019 (Item #15), as amended on May 20, 2020 (Item #7A), as amended on June 10, 2020 (Item #6), as amended on January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), as amended on December 08, 2021 (Item #6-1), as amended on June 15, 2022 (Item # Tabled Item 20A), and as amended on December 21, 2022 (Item #13A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to modify the price limitation and modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify Form P-37, General Provisions, Block 1.8, Price Limitation, to read: \$5,928,058,454
2. Modify Exhibit A, Amendment #9 by replacing it in its entirety with Exhibit A, Amendment #10, which is attached hereto and incorporated by reference herein. Modifications to Exhibit A, Amendment #9 are outlined below:
 - a. Modify Exhibit A, Section 2.1.53.2, to read:
 - 2.1.53.2. A Member cannot be required by the MCO to use the alternative service or setting. Beginning January 3, 2023, all In Lieu Of Services shall be reviewed for consideration and authorization in accordance with federal regulations, as appropriate. [42 CFR 438.3(e)(2)(i) - (iii); SMDL #23-001]
 - b. Modify Exhibit A, Section 3.13.1.1, to read:
 - 3.13.1.1 The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.13 (Compliance with State and Federal Laws), and any laws, regulations or administrative rules effective after the execution of this Agreement. The MCO shall comply with any applicable federal and State laws that pertain to Member rights and ensure that its employees and Participating Providers observe and protect those rights. [42 CFR 438.100(a)(2)]
 - c. Modify Exhibit A, Section 3.13.1.3, to read:
 - 3.13.1.3 The MCO shall comply with all aspects of the DHHS Sentinel Event Reporting and Review Policy PO.1003, and any subsequent versions and/or amendments;
 - d. Modify Exhibit A, Section 3.13.1.3.1, to read:
 - 3.13.1.3.1 The MCO shall 1) cooperate with review of any reported sentinel event, and provide any

additional reporting information requested by DHHS, and 2) participate in a DHHS sentinel event review, if requested;

e. Modify Exhibit A, Section 3.15.1.3.1.3, to read:

3.15.1.3.1.3 For the period January 1, 2021 through August 31, 2024, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions.

f. Modify Exhibit A, Section 3.15.1.3.2.3, to read:

3.15.1.3.2.3 For the period January 1, 2021 through August 31, 2024, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions

g. Modify Exhibit A, Section 3.15.1.3.5.2, to read:

3.15.1.3.5.2 For the period January 1, 2021 through August 31, 2024, the Long Term Care Coordinator position is not required.

h. Modify Exhibit A, Section 3.15.1.3.8.7, to read:

3.15.1.3.8.7 For the period January 1, 2021 through August 31, 2024, the Housing Coordinator position is not required.

i. Modify Exhibit A, Section 3.15.2.2.3.1, to read:

3.15.2.2.3.1 For the period January 1, 2021 through August 31, 2024, the Psychiatric Boarding program's hospital-credentialed Provider position(s) are not required.

j. Modify Exhibit A, Section 3.15.2.3.1, to read:

3.15.2.3.1 For the period January 1, 2021 through August 31, 2024, the Staff for Members at New Hampshire Hospital position is not required.

k. Modify Exhibit A, Section 3.15.2.4.5, to read:

3.15.2.4.5 For the period January 1, 2021 through August 31, 2024, the Behavioral Health Staff position responsible for in-person housing assistance is not required.

l. Modify Exhibit A, Section 4.1.2, Covered Services Table, by adding Footnote #9, to read:

9 For the period July 1, 2021 through August 31, 2024, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

m. Modify Exhibit A, Section 4.1.2, Covered Services Table, by adding Footnote #10, to read:

10 Effective April 1, 2023, certain preventive, restorative, denture and other oral health services are carved-out of the MCM Program and covered under the State's contract with Delta Dental of New Hampshire, Inc. for eligible adults ages 21 years and over. Dental and oral health emergency services for Medicaid enrolled children and adults of all ages will continue to be Covered Services under the MCM Program.

n. Modify Exhibit A, Section 4.1.3.5.1, to read:

4.1.3.5.1 The MCO may provide Members with services or settings that are "In Lieu Of" Services or settings with prior approval and in accordance with federal regulations.

o. Modify Exhibit A, Section 4.1.3.5.1.1, to read:

4.1.3.5.1.1 Intentionally left blank...

p. Modify Exhibit A, Section 4.1.3.5.1.2, to read:

4.1.3.5.1.2 Intentionally left blank.

q. Modify Exhibit A, Section 4.1.3.5.1.3, to read:

4.1.3.5.1.3 Intentionally left blank.

r. Modify Exhibit A, Section 4.1.3.5.1.4, to read:

4.1.3.5.1.4 Intentionally left blank.

s. Add Exhibit A, Section 4.1.3.5.1.5, to read:

4.1.3.5.1.5 Any In Lieu of Services on record prior to January 3, 2023 and proposed for continuation must comply with CMS federal regulations beginning January 1, 2024. [42 CFR 438.3(e)(2)(i) - (iii); SMDL 1/4/23]

t. Modify Exhibit A, Section 4.1.3.5.2, to read:

4.1.3.5.2 Intentionally left blank.

u. Modify Exhibit A, Section 4.1.3.5.3, to read:

4.1.3.5.3 Beginning September 1, 2019, DHHS has authorized medical nutrition, diabetes self-management, and assistance in finding and keeping housing (not including rent), as In Lieu Of Services. This list may be expanded upon or otherwise modified by DHHS through amendments of this Agreement. Previously authorized In Lieu Of Services are scheduled for review and modification as may be necessary to meet federal regulatory compliance effective January 1, 2024.

v. Modify Exhibit A, Section 4.1.3.5.4, to read:

4.1.3.5.4 Intentionally left blank.

w. Modify Exhibit A, Section 4.1.3.5.5, to read:

4.1.3.5.5 The MCO shall support In Lieu of Services reporting, in accordance with federal regulations and Exhibit O.

x. Modify Exhibit A, Section 4.1.9.1.1, to read:

4.1.9.1.1 The MCO shall assume medical necessity for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility.

y. Modify Exhibit A, Section 4.3.6.2.2, to add:

Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)					
Distribution for Period Ending	Health Risk Assessment Completion	Encounter Data Timeliness Completeness and Quality	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Total Possible Members Awarded by Period
9/30/2023	2,000			1,000	3,000
12/31/2023	2,000		1,000		3,000
3/31/2024		1,000	1,000	1,000	3,000
6/30/2024		3,000			3,000
8/31/2024			2,000		2,000

z. Modify Exhibit A, Section 4.4.1.4.4.3.3 (8) to read:

(8) The cultural and linguistic capabilities of Participating Providers, including languages (including American Sign Language (ASL)) offered by the Provider or a skilled medical

interpreter at the Provider's office;

aa. Modify Exhibit A, Section 4.5.3.8, to read:

4.5.3.8 The MCO shall provide the Member and the Member's representative an opportunity to receive the Member's case file, free of charge prior and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b) - (c)].

bb. Modify Exhibit A, Section 4.10.8.1.1, to read:

4.10.8.1.1 As described in this Section 4.10.8, Local Care Management is optional for the period January 1, 2021 through August 31, 2024.

cc. Modify Exhibit A, Section 4.10.8.1.1.1, to read:

4.10.8.1.1.1 For the period July 1, 2021 through August 31, 2024, the term "Local Care Management" shall also mean "Care Management" in this Section 4.10.8.

dd. Modify Exhibit A, Section 4.11.2.2.1, to read:

4.11.2.2.1 For the period July 1, 2021 through August 31, 2024, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

ee. Modify Exhibit A, Section 4.11.5.7.2.1, to read:

4.11.5.7.2.1 For the period January 1, 2021 through August 31, 2024, the Housing Coordinator position is not required.

ff. Modify Exhibit A, Section 4.11.5.17.1.1., to read:

4.11.5.17.1.1. For the period January 1, 2021 through August 31, 2024, the Psychiatric Boarding program's hospital-credentialed Provider position(s) described in Sections 4.11.5.17.1 through 4.11.5.17.4, and 4.11.5.17.6 are not required.

gg. Modify Exhibit A, Section 4.15.5.4.1, to read:

4.15.5.4.1 The MCO shall limit any MOE clawback that is determined to fifty percent (50%) for the period July 1, 2023 through August 31, 2024; and limit MOE clawback to seventy percent (70%) for the period January 1, 2023 through June 30, 2023.

hh. Modify Exhibit A, Section 4.15.5.5.4, to read:

4.15.5.5.4 For the rating period July 1, 2023 through August 31, 2024, directed payment amounts determined by DHHS shall comprise a fee schedule adjustment or uniform dollar increase for assertive community treatment, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, consistent illness management and recovery services, and step down community residence beds for individuals dually diagnosed with serious mental illness and developmental disabilities, within the Community Mental Health Programs class of network providers as approved by CMS, including any alternate CMS-approved directed payment methodology.

ii. Modify Exhibit A, Section 4.15.5.6.2, to read:

4.15.5.6.2 For the rating period July 1, 2023 through August 31, 2024, directed payment remittance shall comprise a minimum fee schedule at least at the FFS rates established by DHHS for Community Residential Services.

jj. Modify Exhibit A, Section 4.15.10, by adding Subsection 4.15.10.1.5, to read:

4.15.10.1.5 For the rating period July 1, 2023 through August 31, 2024, MCO provider

reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

kk. Modify Exhibit A, Section 4.15.13, Subsection 4.15.13.1, by adding Subsection 4.15.13.1.4, to read:

4.15.13.1.4 For the rating period July 1, 2023 through August 31, 2024, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology. Qualified directed payments are tied to actual hospital services, including the number of inpatient discharges and outpatient visits reported by qualifying Providers.

ll. Modify Exhibit A, Section 4.15.14, Subsection 4.15.14.1, by adding Subsection 4.15.14.1.3, to read:

4.15.14.1.3 For the July 1, 2023 through August 31, 2024 rating period, the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 State Plan DRG fee schedule payment amounts described in Section 6.2.41.1.

mm. Modify Exhibit A, Section 4.15.15, Subsection 4.15.15.1, by adding Subsection 4.15.15.1.3, to read:

4.15.15.1.3 For the rating period July 1, 2023 through August 31, 2024, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

nn. Modify Exhibit A, Section 4.15.16.1, to read:

4.15.16.1 The MCO shall reimburse inpatient psychiatric services delivered in state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

oo. Modify Exhibit A, Section 4.15.16.1.2, to read:

4.15.16.1.2 For the rating period July 1, 2023 through August 31, 2024, the facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

pp. Modify Exhibit A, Section 4.15.16, by adding Subsection 4.15.16.2, to read:

4.15.16.2 The MCO shall reimburse inpatient psychiatric professional services delivered in the state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

qq. Modify Exhibit A, Section 4.15.16, by adding Subsection 4.15.16.2.1, to read:

4.15.16.2.1 For the rating period July 1, 2023 through August 31, 2024, directed payment amounts shall comprise minimum fee schedule payments at no less than the Medicare rates for inpatient psychiatric professional services delivered in the state-owned facilities.

rr. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.17, to read:

4.15.17 Payment Standard for Birthing Centers

ss. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.17.1, to read:

4.15.17.1 For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services at no less than NH Medicaid fee schedule rates.

- tt. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.18, to read:
 - 4.15.18 Qualifying Children's Hospitals
 - uu. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.18.1, to read:
 - 4.15.18.1 The MCO shall remit directed payments to qualifying Children's Hospitals substantively serving NH Medicaid Members, in accordance with separate guidance, as follows:
 - vv. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.18.2, to read:
 - 4.15.18.2 For the rating period July 1, 2023 through August 31, 2024, a directed payment add-on amount in addition to the MCO's negotiated rate shall be awarded to qualifying Children's Hospitals for each eligible inpatient and outpatient hospital service encounter as approved by CMS.
 - ww. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.19, to read:
 - 4.15.19 Payment Standard for Ambulance Services
 - xx. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.19.1, to read:
 - 4.15.19.1 For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Providers for all ambulance and chair car Covered Services at no less than NH Medicaid fee schedule rates.
 - yy. Modify Exhibit A, Section 5.3.7.3, to read:
 - 5.3.7.3 The MCO and the MCO's Providers and Subcontractors shall permit DHHS, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises at any time to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours.
 - zz. Modify Exhibit A, Section 5.4.5.1.2, by adding Section 5.4.5.1.2.1, to read:
 - 5.4.5.1.2.1 The MCO shall be eligible for a maximum withhold capitation credit for the July 1, 2023 through August 31, 2024 rating period up to 0.15% based on Members who have completed their redeterminations between July 1, 2023 through October 31, 2023 as described in the MCM Withhold and Incentive Guidance.
 - aaa. Modify Exhibit A, Section 5.4.5, by adding Section 5.4.5.2, to read:
 - 5.4.5.2 The MCO may be eligible for additional monetary incentives from the unearned withhold funds related to performance of activities to enhance care management and administrative practices including, but not limited to: fraud, waste, and abuse; medication reviews; polypharmacy; substance use disorder; and opioid treatment provider oversight and compliance as described in separate guidance.
 - bbb. Modify Exhibit A, Section 6.2.12.1, to read:
 - 6.2.12.1 The September 2019 to August 31, 2024 capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.
 - ccc. Modify Exhibit A, Section 6.2.12., by adding Section 6.2.12.3, to read:
 - 6.2.12.3 For the rating period July 1, 2023 through August 31, 2024 capitation rates include a preliminary acuity adjustment based on DHHS's intended PHE unwind process and a detailed redetermination schedule to estimate the percentage of Members expected to leave the Medicaid program for each redetermination cohort as explained in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid

Services for this rating period Amendment. The adjustment will be updated for Amendment #11 capitation rates, as appropriate.

ddd. Modify Exhibit A, Section 6.2.36.1, by adding Subsection 6.2.36.1.4, to read:

6.2.36.1.4 For the period July 1, 2023 through August 31, 2024, the attachment point shall be \$740,000.

eee. Modify Exhibit A, Section 6.2.38.2, to read:

6.2.38.2 For the contract period July 1, 2023 through August 31, 2024, the cost of the COVID-19 vaccines and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

fff. Modify Exhibit A, Section 6.2.41, to read:

6.2.41 For the July 1, 2023 through August 31, 2024 rating period, DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG codes 880-887, except as described in Section 6.2.41.3 below.

ggg. Modify Exhibit A, Section 6.3.4.1, to read:

6.3.4.1 For the period July 1, 2023 through August 31, 2024, the target MLR for at-risk services is 90.8% for Standard Medicaid and 89.9% for GAHCP based on the projected enrollment distribution for the rating period. Please note, each program's target MLR may change in future rate amendments as a result of changes to underlying assumptions, such as enrollment projections, emerging utilization experience, and the retroactive acuity adjustments, if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

hhh. Modify Exhibit A, Section 6.3.4.1.1, to read:

6.3.4.1.1 The minimum MLR is set on a program-wide basis for each major population, such that the maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). The minimum MLR shall be 88.3% for the Standard Medicaid population and 87.4% for the GAHCP population.

iii. Modify Exhibit A, Section 6.3.4.1.2, to read:

6.3.4.1.2 The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCOs will have a maximum loss of 2.0%. Based on the target MLRs, the maximum MLR shall be 94.3% for the Standard Medicaid population and 93.4% for the GAHCP population.

3. Modify Exhibit B, Amendment #9 by replacing it in its entirety with Exhibit B, Amendment #10, which is attached hereto and incorporated by reference herein.

4. Modify Exhibit O, Amendment #9 by replacing it in its entirety with Exhibit O, Amendment #10, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment remain in full force and effect. This Amendment shall be effective July 1, 2023, subject to Governor and Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

5/26/2023

Date

DocuSigned by:
Henry D. Lipman
Name: Henry D. Lipman
Title: Medicaid Director

AmeriHealth Caritas New Hampshire Inc.

5/26/2023

Date

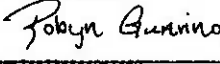
DocuSigned by:
William Keena
Name: William Keena
Title: Market President, New Hampshire

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

5/27/2023

Date

DocuSigned by:

Name: Robyn Guarino
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:



Medicaid Care Management
Services Contract

EXHIBIT A – AMENDMENT #10

SCOPE OF SERVICES

Medicaid Care Management Services Contract



New Hampshire Department of Health and Human Services
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1 INTRODUCTION

1.1 Purpose

1.1.1 This Medicaid Care Management Agreement is a comprehensive full risk prepaid capitated Agreement that sets forth the terms and conditions for the Managed Care Organization's (MCO's) participation in the New Hampshire (NH) Medicaid Care Management (MCM) program.

1.1.2 ~~[Amendment #1:] All terms and conditions of the Agreement not inconsistent with this Agreement #1 remain in full force and effect.~~

1.2 Term

1.2.1 The Agreement and all contractual obligations, including Readiness Review, shall become effective on the date the Governor and Executive Council approves the executed MCM Agreement or, if the MCO does not have health maintenance organization (HMO) licensure in the State of New Hampshire on the date of Governor and Executive Council approval, the date the MCO obtains HMO licensure in the State of New Hampshire, whichever is later.

1.2.1.1 If the MCO fails to obtain HMO licensure within thirty (30) calendar days of Governor and Executive Council approval, this Agreement shall become null and void without further recourse to the MCO.

1.2.2 ~~[Amendment #1:] The Program Start Date shall begin September 1, 2019, and the Agreement term shall continue through August 31, 2024.~~

~~[Base Contract:] The Program Start Date shall begin on July 1, 2019, and the Agreement term shall continue through June 30, 2024.~~

1.2.3 The MCO's participation in the MCM program is contingent upon approval by the Governor and Executive Council, the MCO's successful completion of the Readiness Review process as determined by DHHS, and obtaining HMO licensure in the State of New Hampshire as set forth above.

1.2.4 The MCO is solely responsible for the cost of all work during the Readiness Review and undertakes the work at its sole risk.

1.2.5 ~~[Amendment #1:] If DHHS determines that any MCO will not be ready to begin providing services on the MCM Program Start Date, September 1, 2019, at its sole discretion, DHHS may withhold enrollment and require corrective action or terminate the Agreement without further recourse to the MCO.~~

~~[Base Contract:] If DHHS determines that any MCO will not be ready to begin providing services on the MCM Program Start Date, July 1, 2019, at its sole discretion, DHHS may withhold enrollment and require corrective action or terminate the Agreement without further recourse to the MCO.~~

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2 DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.1 Adults with Special Health Care Needs

2.1.1.1 "Adults with Special Health Care Needs" means Members who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age.

2.1.1.1.1 This includes, but is not limited to Members with: Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); a Severe Mental Illness (SMI), Serious Emotional Disturbance (SED), Intellectual and/or Developmental Disability (I/DD), Substance Use Disorder diagnosis; or chronic pain.

2.1.2 Advance Directive

2.1.2.1 "Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of New Hampshire, relating to the provision of health care when a Member is incapacitated. [42 CFR 489.100]

2.1.3 Affordable Care Act

2.1.3.1 "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted on March 30, 2010.

2.1.4 Agreement

2.1.4.1 "Agreement" means this entire written Agreement between DHHS and the MCO, including its exhibits.

2.1.5 American Society of Addiction Medicine (ASAM) Criteria

2.1.5.1 "American Society of Addiction Medicine (ASAM) Criteria" means a national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. The Criteria provides guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.¹

¹ The American Society of Addiction Medicine, "What is the ASAM Criteria"

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2.1.6 Americans with Disabilities Act (ADA)

2.1.6.1 "Americans with Disabilities Act (ADA)" means a civil rights law that prohibits discrimination against Members with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.²

2.1.7 Appeal Process

2.1.7.1 "Appeal Process" means the procedure for handling, processing, collecting and tracking Member requests for a review of an adverse benefit determination which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.8 Area Agency

2.1.8.1 "Area Agency" means an entity established as a nonprofit corporation in the State of New Hampshire which is established by rules adopted by the Commissioner to provide services to developmentally disabled persons in the area as defined in RSA 171-A:2.

2.1.9 ASAM Level of Care

2.1.9.1 "ASAM Level of Care" means a standard nomenclature for describing the continuum of recovery-oriented addiction services. With the continuum, clinicians are able to conduct multidimensional assessments that explore individual risks and needs, and recommended ASAM Level of Care that matches intensity of treatment services to identified patient needs.

2.1.10 Assertive Community Treatment (ACT)

2.1.10.1 "Assertive Community Treatment (ACT)" means the evidence-based practice of delivering comprehensive and effective services to Members with SMI by a multidisciplinary team primarily in Member homes, communities, and other natural environments.

2.1.11 Auxiliary Aids

2.1.11.1 "Auxiliary Aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy, the benefits of programs or activities conducted by the MCO.

2.1.11.1.1 Such aids include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible

² The Americans with Disability Act National Network, "What is the Americans with Disabilities Act"

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with hearing aids, telecommunication devices for deaf persons (TDDs), interpreters, note takers, written materials, and other similar services and devices.

2.1.12 Behavioral Health Services

2.1.12.1 "Behavioral Health Services" means mental health and Substance Use Disorder services that are Covered Services under this Agreement.

2.1.13 [Amendment #7:] Intentionally Left Blank Behavioral Health-Crisis Treatment Center (BHCTC)

~~2.1.13.1 [Amendment #7:] "Behavioral Health-Crisis Treatment Center (BHCTC)" means a treatment service center that provides twenty-four (24) hours a day, seven (7) days a week intensive, short term stabilization treatment services for Members experiencing a mental health crisis, including those with co-occurring Substance Use Disorder.~~

~~2.1.13.2 [Amendment #7:] The BHCTC accepts Members for treatment on a voluntary basis who walk in, are transported by first responders, or as a stepdown treatment site post emergency department (ED) visit or inpatient psychiatric treatment site.~~

~~2.1.13.3 [Amendment #7:] The BHCTC delivers an array of services to de-escalate and stabilize Members at the intensity and for the duration necessary to quickly and successfully discharge, via specific after care plans, the Member back into the community or to a step-down treatment site.~~

2.1.14 Bright Futures

2.1.14.1 "Bright Futures" means a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) that provides theory-based and evidence-driven guidance for all preventive care screenings and well-child visits.

2.1.15 Capitation Payment

2.1.15.1 "Capitation Payment" means the monthly payment by DHHS to the MCO for each Member enrolled in the MCO's plan for which the MCO provides Covered Services under this Agreement.

2.1.15.1.1 Capitation payments are made only for Medicaid-eligible Members and retained by the MCO for those Members. DHHS makes the payment regardless of whether the Member receives services during the period covered by the payment. [42 CFR 438.2]

2.1.16 Care Coordination

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2.1.16.1 [Amendment #2:] "Care Coordination" means the interaction with established local community-based providers of care, including Local Care Management Networks entities, to address the physical, behavioral health and psychosocial needs of Members.

2.1.17 Care Management

2.1.17.1 ""Care Management" means direct contact with a Member focused on the provision of various aspects of the Member's physical, behavioral health and needed supports that will enable the Member to achieve the best health outcomes.

2.1.18 Care Manager

2.1.18.1 [Amendment #2:] "Care Manager" means a qualified and trained individual who is hired directly by the MCO, a provider in the MCO's network (a "Participating Provider"), or a provider for a Local Care Management Network entity with which the MCO contracts who is primarily responsible for providing Care Coordination and Care Management services as defined by this Agreement.

2.1.19 Case Management

2.1.19.1 "Case Management" means services that assist Members in gaining access to needed waivers and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

2.1.20 Centers for Medicare & Medicaid Services (CMS)

2.1.20.1 "Centers for Medicare & Medicaid Services (CMS)" means the federal agency within the United States Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare programs.

2.1.21 Children with Special Health Care Needs

2.1.21.1 "Children with Special Health Care Needs" means Members under age twenty-one (21) who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age.

2.1.21.1.1 This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with Neonatal Abstinence Syndrome (NAS); in high stress social environments/caregiver stress; receiving Family Centered Early

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Supports and Services, or participating in Special Medical Services or Partners in Health Services with a SED, I/DD or Substance Use Disorder diagnosis.

2.1.22 Children's Health Insurance Program (CHIP)

2.1.22.1 "Children's Health Insurance Program (CHIP)" means a program to provide health coverage to eligible children under Title XXI of the Social Security Act.

2.1.23 Choices for Independence (CFI)

2.1.23.1 "Choices for Independence (CFI)" means the Home and Community-Based Services (HCBS) 1915(c) waiver program that provides a system of Long Term Services and Supports (LTSS) to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities.

2.1.23.2 The CFI waiver is also known as HCBS for the Elderly and Chronically Ill (HCBS-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and Covered Services are identified in He-E 801.

2.1.24 Chronic Condition

2.1.24.1 "Chronic Condition" means a physical or mental impairment or ailment of indefinite duration or frequent recurrence such as heart disease, stroke, cancer, diabetes, obesity, arthritis, mental illness or a Substance Use Disorder.

2.1.25 Clean Claim

2.1.25.1 ~~[Amendment #7:] [Amendment #6:]~~ "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a health plan's State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. [42 CFR 447.45(b)] ~~"Clean Claim" means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.~~

2.1.26 Cold Call Marketing

2.1.26.1 "Cold Call Marketing" means any unsolicited personal contact by the MCO or its designee, with a potential Member or a

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Member with another contracted MCO for the purposes of Marketing.
[42 CFR 438.104(a)]

2.1.27 Community Mental Health Services

2.1.27.1 "Community Mental Health Services" means mental health services provided by a Community Mental Health Program ("CMH Program") or Community Mental Health Provider ("CMH Provider") to eligible Members as defined under He-M 426.

2.1.28 Community Mental Health Program ("CMH Program")

2.1.28.1 "Community Mental Health Program ("CMH Program")", synonymous with Community Mental Health Center, means a program established and administered by the State of New Hampshire, city, town, or county, or a nonprofit corporation for the purpose of providing mental health services to the residents of the area and which minimally provides emergency, medical or psychiatric screening and evaluation, Case Management, and psychotherapy services; [RSA 135-C:2, IV] A CMH Program is authorized to deliver the comprehensive array of services described in He-M 426 and is designated to cover a region as described in He-M 425.

2.1.29 Community Mental Health Provider ("CMH Provider")

2.1.29.1 "Community Mental Health Provider ("CMH Provider")" means a Medicaid Provider of Community Mental Health Services that has been previously approved by the DHHS Commissioner to provide specific mental health services pursuant to He-M 426 [He-M 426.02: (g)]. The distinction between a CMH Program and a CMH Provider is that a CMH Provider offers a more limited range of services.

2.1.30 Comprehensive Assessment

2.1.30.1 "Comprehensive Assessment" means a person-centered assessment to help identify a Member's health condition, functional status, accessibility needs, strengths and supports, health care goals and other characteristics to inform whether a Member requires Care Management services and the level of services that should be provided.

2.1.31 Confidential Information

2.1.31.1 "Confidential Information" or "Confidential Data" means information that is exempt from disclosure to the public or other unauthorized persons under State or federal law. Confidential Information includes, but is not limited to, personal information (PI). See definition also listed in Exhibit K.

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2.1.32 Consumer Assessment of Health Care Providers and Systems (CAHPS®)

2.1.32.1 "Consumer Assessment of Health Care Providers and Systems (CAHPS®)" means a family of standardized survey instruments, including a Medicaid survey, used to measure Member experience of health care.

2.1.33 Continuity of Care

2.1.33.1 "Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through Member transitions between: facilities and home; facilities; Providers; service areas; managed care contractors; Marketplace, Medicaid fee-for-service (FFS) or private insurance and managed care arrangements. Continuity of Care occurs in a manner that prevents unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

2.1.34 Continuous Quality Improvement (CQI)

2.1.34.1 "Continuous Quality Improvement (CQI)" means the systematic process of identifying, describing, and analyzing strengths and weaknesses and then testing, implementing, learning from, and revising solutions.

2.1.35 Copayment

2.1.35.1 "Copayment" means a monetary amount that a Member pays directly to a Provider at the time a covered service is rendered.

2.1.36 Corrective Action Plan (CAP)

2.1.36.1 "Corrective Action Plan (CAP)" means a plan that the MCO completes and submits to DHHS to identify and respond to any issues and/or errors in instances where it fails to comply with DHHS requirements.

2.1.37 Covered Services

2.1.37.1 "Covered Services" means health care services as defined by DHHS and State and federal regulations and includes Medicaid State Plan services specified in this Agreement, In Lieu of Services, any Value-Added Services agreed to by the MCO in the Agreement, and services required to meet Mental Health Parity and Addiction Equity Act.

2.1.38 [Amendment #2:] Designated Local Care Management Networks Entities

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[Amendment #2:] "Designated Local Care Management Networks Entities" means Integrated Delivery Networks (IDNs) that have been certified as Designated Local Care Management Networks Entities by DHHS; Health Homes, if DHHS elects to implement Health Homes under the Medicaid State Plan Amendment authority; and other contracted entities capable of performing Local Care Management for a designated cohort of Members, as determined by DHHS.

2.1.39 Designated Receiving Facility

2.1.39.1 "Designated Receiving Facility" means a hospital-based psychiatric unit or a non-hospital-based residential treatment program designated by the Commissioner to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system as defined in He-M 405.

2.1.40 Dual-Eligible Members

2.1.40.1 "Dual-Eligible Members" means Members who are eligible for both Medicare and Medicaid.

2.1.41 Emergency Medical Condition

2.1.41.1 "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the Member (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]

2.1.42 Emergency Services

2.1.42.1 "Emergency Services" means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition. [42 CFR 438.114(a)]

2.1.43 Equal Access

2.1.43.1 "Equal Access" means all Members have the same access to all Providers and services.

2.1.44 Evidence-Based Supported Employment (EBSE)

2.1.44.1 "Evidence-Based Supported Employment (EBSE)" means the provision of vocational supports to Members following the Supported Employment Implementation Resource Kit developed by

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Dartmouth Medical School to promote successful competitive employment in the community.

2.1.45 Exclusion Lists

2.1.45.1 "Exclusion Lists" means HHS Office of the Inspector General's (OIG) List of Excluded Individuals/Entities; the System of Award Management; the Social Security Administration Death Master File; the list maintained by the Office of Foreign Assets Controls; and to the extent applicable, National Plan and Provider Enumeration System (NPES).

2.1.46 External Quality Review (EQR)

2.1.46.1 "External Quality Review (EQR)" means the analysis and evaluation described in 42 CFR 438.350 by an External Quality Review Organization (EQRO) detailed in 42 CFR 438.42 of aggregated information on quality, timeliness, and access Covered Services that the MCO or its Subcontractors furnish to Medicaid recipients.

2.1.47 Family Planning Services

2.1.47.1 "Family Planning Services" means services available to Members by Participating or Non-Participating Providers without the need for a referral or Prior Authorization that include:

2.1.47.1.1 Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

2.1.47.1.2 Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

2.1.47.1.3 Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

2.1.47.1.4 Referral of Members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

2.1.47.1.5 Immunization services where medically indicated and linked to sexually transmitted diseases, including but not limited to Hepatitis B and Human papillomaviruses vaccine.

2.1.48 Federally Qualified Health Centers (FQHCs)

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2.1.48.1 "Federally Qualified Health Center (FQHC)" means a public or private non-profit health care organization that has been identified by the Health Resources and Services Administration (HRSA) and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.

2.1.49 Granite Advantage Members

2.1.49.1 "Granite Advantage Members" means Members who are covered under the NH Granite Advantage waiver, which includes individuals in the Medicaid new adult eligibility group, covered under Title XIX of the Social Security Act who are adults, aged nineteen (19) up to and including sixty-four (64) years, with incomes up to and including one hundred and thirty-eight percent (138%) of the federal poverty level (FPL) who are not pregnant, not eligible for Medicare and not enrolled in NH's Health Insurance Premium Payment (HIPP) program.

2.1.50 Grievance Process

2.1.50.1 "Grievance Process" means the procedure for addressing Member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.51 Home and Community Based Services (HCBS)

2.1.51.1 "Home and Community Based Services (HCBS)" means the waiver of Sections 1902(a)(10) and 1915(c) of the Social Security Act, which permits the federal Medicaid funding of LTSS in non-institutional settings for Members who reside in the community or in certain community alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility (ICF). This includes services provided under the HCBS-CFI waiver program, Developmental Disabilities (HCBS-DD) waiver program, Acquired Brain Disorders (HCBS-ABD) waiver program, and In Home Supports (HCBS-I) waiver program.

2.1.52 Hospital-Acquired Conditions and Provider Preventable Conditions

2.1.52.1 "Hospital-Acquired Conditions and Provider Preventable Conditions" means a condition that meets the following criteria: Is identified in the Medicaid State Plan; has been found by NH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Member; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a

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Member, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong Member.

2.1.53 In Lieu Of Services

2.1.53.1 An "In Lieu Of Service" means an alternative service or setting that DHHS has approved as medically appropriate and cost-effective substitute for a Covered Service or setting under the Medicaid State Plan.

2.1.53.2 [Amendment #10:] A Member cannot be required by the MCO to use the alternative service or setting. Beginning January 3, 2023, all Any In Lieu Of Services shall be reviewed for consideration and shall be authorized in accordance with federal regulations, as appropriate by DHHS, either via DHHS's issuance of prospective identification of approved In Lieu of Services or through an agreement reached between DHHS and the MCO. [42 CFR 438.3(e)(2)(i) - (iii); SMDL #23-001]

2.1.53.3 The utilization and actual cost of In Lieu Of Services shall be taken into account in developing the component of the capitation rates that represents the Medicaid State Plan Covered Services, unless a statute or regulation explicitly requires otherwise.

2.1.54 Incomplete Claim

2.1.54.1 "Incomplete Claim" means a claim that is denied for the purpose of obtaining additional information from the Provider.

2.1.55 Indian Health Care Provider (IHCP)

2.1.55.1 "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in the Indian Health Care Improvement Act (25 U.S.C. 1603). [42 CFR 438.14(a)]

2.1.56 Integrated Care

2.1.56.1 "Integrated Care" means the systematic coordination of mental health, Substance Use Disorder, and primary care services to effectively care for people with multiple health care needs.³

2.1.57 Integrated Delivery Network (IDN)

2.1.57.1 "Integrated Delivery Network" means a regionally-based network of physical and behavioral health providers and/or social

³ SAMHSA-HRSA Center for Integrated Solutions, "What is Integrated Care?"

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service organizations that participate in the NH Building Capacity for Transformation Section 1115 Waiver or are otherwise determined by DHHS to be an Integrated Delivery Network.

2.1.57.2 [Amendment #8:] Effective December 31, 2020, the phrase "Integrated Delivery Network" and acronym "IDN" is retained as informational due to the expiration of the NH Building Capacity for Transformation Section 1115 Waiver.

2.1.58 Limited English Proficiency (LEP)

2.1.58.1 "Limited English Proficiency (LEP)" means a Member's primary language is not English and the Member may have limited ability to read, write, speak or understand English.

2.1.59 Local Care Management

2.1.59.1 "Local Care Management" means the MCO engages in real-time, high-touch, or a supportive in-person Member engagement strategy used for building relationships with Members that includes consistent follow-up with Providers and Members to assure that selected Members are making progress with their care plans:

2.1.60 Long Term Services and Supports (LTSS)

2.1.60.1 "Long Term Services and Supports (LTSS)" means nursing facility services, all four of NH's Home and Community Based Care waivers, and services provided to children and families through the Division for Children, Youth and Families (DCYF).

2.1.61 Managed Care Information System (MCIS)

2.1.61.1 "Managed Care Information System (MCIS)" means a comprehensive, automated and integrated system that: collects, analyzes, integrates, and reports data [42 CFR 438.242(a)]; provides information on areas, including but not limited to utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility [42 CFR 438.242(a)]; collects and maintains data on Members and Providers, as specified in this Agreement and on all services furnished to Members, through an encounter data system [42 CFR 438.242(b)(2)]; is capable of meeting the requirements listed throughout this Agreement; and is capable of providing all of the data and information necessary for DHHS to meet State and federal Medicaid reporting and information regulations.

2.1.62 Managed Care Organization (MCO)

2.1.62.1 "Managed Care Organization (MCO)" means an entity that has a certificate of authority from the NH Insurance Department

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(NHID) and who contracts with DHHS under a comprehensive risk Agreement to provide health care services to eligible Members under the MCM program.

2.1.63 Marketing

2.1.63.1 "Marketing" means any communication from the MCO to a potential Member, or Member who is not enrolled in that MCO, that can reasonably be interpreted as intended to influence the Member to enroll with the MCO or to either not enroll, or disenroll from another DHHS contracted MCO. [42 CFR 438.104(a)]

2.1.64 Marketing Materials

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as Marketing to potential Members. [42 CFR 438.104(a)(ii)]

2.1.65 MCO Alternative Payment Model (APM) Implementation Plan

2.1.65.1 "MCO Alternative Payment Model (APM) Implementation Plan" means the MCO's plan for meeting the APM requirements described in this Agreement. The MCO APM Implementation Plan shall be reviewed and approved by DHHS.

2.1.66 MCO Data Certification

2.1.66.1 "MCO Data Certification" means data submitted to DHHS and certified by one of the following:

2.1.66.1.1 The MCO's Chief Executive Officer (CEO);

2.1.66.1.2 The MCO's Chief Financial Officer (CFO); or

2.1.66.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO.

2.1.67 MCO Formulary

2.1.67.1 "MCO Formulary" means the list of prescription drugs covered by the MCO and the tier on which each medication is placed, in compliance with the DHHS-developed Preferred Drug List (PDL) and 42 CFR 438.10(i).

2.1.68 MCO Quality Assessment and Performance Improvement (QAPI) Program

2.1.68.1 "MCO Quality Assessment and Performance Improvement (QAPI) Program" means an ongoing and comprehensive program for the services the MCO furnishes to Members consistent with the requirements of this Agreement and

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federal requirements for the QAPI program. [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)]

2.1.69 MCO Utilization Management Program

2.1.69.1 "MCO Utilization Management Program" means a program developed, operated, and maintained by the MCO that meets the criteria contained in this Agreement related to Utilization Management. The MCO Utilization Management Program shall include defined structures, policies, and procedures for Utilization Management.

2.1.70 Medicaid Director

2.1.70.1 "Medicaid Director" means the State Medicaid Director of NH DHHS.

2.1.71 Medicaid Management Information System (MMIS)

2.1.71.1 "Medicaid Management Information System (MMIS)" as defined by the CMS.gov glossary is: a CMS approved system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, Surveillance and Utilization Review Subsystem (SURS), Management and Administrative Reporting System (MARS), and potentially encounter processing.

2.1.72 Medicaid State Plan

2.1.72.1 "Medicaid State Plan" means an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state.

2.1.73 Medical Loss Ratio (MLR)

2.1.73.1 "Medical Loss Ratio (MLR)" means the proportion of premium revenues spent on clinical services and quality improvement, calculated in compliance with the terms of this Agreement and with all federal standards, including 42 CFR 438.8.

2.1.74 Medically Necessary

2.1.74.1 Per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Members under twenty-one (21) years of age,

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"Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

2.1.74.2 For Members twenty-one (21) years of age and older, "Medically Necessary" means services that a licensed Provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

2.1.74.2.1 Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the Member's illness, injury, disease, or its symptoms;

2.1.74.2.2 Not primarily for the convenience of the Member or the Member's family, caregiver, or health care Provider;

2.1.74.2.3 No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the Member's illness, injury, disease, or its symptoms; and

2.1.74.2.4 Not experimental, investigative, cosmetic, or duplicative in nature [He-W 530.01(e)].

2.1.75 Medication Assisted Treatment (MAT)

2.1.75.1 "Medication Assisted Treatment (MAT)" means the use of medications in combination with counseling and behavioral therapies for the treatment of Substance Use Disorder.⁴

2.1.76 Member

2.1.76.1 "Member" means an individual who is enrolled in managed care through an MCO having an Agreement with DHHS. [42 CFR 438.10(a)]

2.1.77 Member Advisory Board

2.1.77.1 "Member Advisory Board" means a group of Members that represents the Member population, established and facilitated by the MCO. The Member Advisory Board shall adhere to the requirements set forth in this Agreement.

⁴ SAHMSA-HRSA Center for Integrated Health Solutions, "Medication Assisted Treatment"

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2.1.78 Member Encounter Data (Encounter Data)

2.1.78.1 "Member Encounter Data ("Encounter Data")" means the information relating to the receipt of any item(s) or service(s) by a Member, under this Agreement, between DHHS and an MCO that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818.

2.1.79 Member Handbook

2.1.79.1 "Member Handbook" means a handbook based upon the model Member Handbook developed by DHHS and published by the MCO that enables the Member to understand how to effectively use the MCM program in accordance with this Agreement and 42 CFR 438.10(g).

2.1.80 National Committee for Quality Assurance (NCQA)

2.1.80.1 "National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

2.1.81 NCQA Health Plan Accreditation

"NCQA Health Plan Accreditation" means MCO accreditation, including the Medicaid module obtained from the NCQA, based on an assessment of clinical performance and consumer experience.

2.1.82 Neonatal Abstinence Syndrome (NAS)

2.1.82.1 "Neonatal Abstinence Syndrome (NAS)" means a constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids.⁵

2.1.83 Non-Emergency Medical Transportation (NEMT)

2.1.83.1 "Non-Emergency Medical Transportation (NEMT)" means transportation services arranged by the MCO and provided free of charge to Members who are unable to pay for the cost of transportation to Provider offices and facilities for Medically Necessary care and services covered by the Medicaid State Plan, regardless of whether those Medically Necessary services are covered by the MCO.

2.1.84 Non-Participating Provider

2.1.84.1 "Non-Participating Provider" means a person, health care Provider, practitioner, facility or entity acting within their scope of

⁵ CMCS Informational Bulletin, "Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants," Centers for Medicare and Medicaid Services, June 11, 2018

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practice or licensure, that does not have a written Agreement with the MCO to participate in the MCO's Provider network, but provides health care services to Members under appropriate scenarios (e.g., a referral approved by the MCO).

2.1.85 Non-Symptomatic Office Visits

2.1.85.1 "Non-Symptomatic Office Visits" means preventive care office visits available from the Member's Primary Care Provider (PCP) or another Provider within forty-five (45) calendar days of a request for the visit. Non-Symptomatic Office Visits may include, but are not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

2.1.86 Non-Urgent, Symptomatic Office Visits

2.1.86.1 "Non-Urgent, Symptomatic Office Visits" means routine care office visits available from the Member's PCP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of medical signs or symptoms not requiring immediate attention, but that require monitoring.

2.1.87 Ongoing Special Condition

2.1.87.1 "Ongoing Special Condition" means, in the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm; in the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; in the case of pregnancy, pregnancy from the start of the second trimester; in the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

2.1.88 Overpayments

2.1.88.1 "Overpayments" means any amount received to which the Provider is not entitled. An overpayment includes payment that should not have been made and payments made in excess of the appropriate amount.

2.1.89 Participating Provider

2.1.89.1 "Participating Provider" means a person, health care Provider, practitioner, facility, or entity, acting within the scope of practice and licensure, and who is under a written contract with the

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MCO to provide services to Members under the terms of this Agreement.

2.1.90 Peer Recovery Program

2.1.90.1 "Peer Recovery Program" means a program that is accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or another accrediting body approved by DHHS, is under contract with DHHS's contracted facilitating organization, or is under contract with DHHS's Bureau of Drug and Alcohol Services to provide Peer Recovery Support Services (PRSS).

2.1.91 Performance Improvement Project (PIP)

2.1.91.1 "Performance Improvement Project (PIP)" means an initiative included in the QAPI program that focuses on clinical and non-clinical areas. A PIP shall be developed in consultation with the EQRO. [42 CFR 438.330(b)(1); 42 CFR 438.330(d)(1); 42 CFR 438.330(a)(2)].

2.1.92 Physician Group

2.1.92.1 "Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its Members. An individual practice association is a Physician Group only if it is composed of individual physicians and has no Subcontracts with Physician Groups.

2.1.93 Physician Incentive Plan

2.1.93.1 "Physician Incentive Plan" means any compensation arrangement between the MCO and Providers that apply to federal regulations found at 42 CFR 422.208 and 42 CFR 422.210, as applicable to Medicaid managed care on the basis of 42 CFR 438.3(i).

2.1.94 Post-Stabilization Services

2.1.94.1 "Post-Stabilization Services" means contracted services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition. [42 CFR 438.114; 422.113]

2.1.95 Practice Guidelines

2.1.95.1 "Practice Guidelines" means evidence-based clinical guidelines adopted by the MCO that are in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines shall be based on valid and reasonable

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clinical evidence or a consensus of Providers in the particular field, shall consider the needs of Members, be adopted in consultation with Participating Providers, and be reviewed and updated periodically as appropriate.

2.1.96 Prescription Drug Monitoring Program (PDMP)

2.1.96.1 "Prescription Drug Monitoring Program (PDMP)" means the program operated by the NH Office of Professional Licensure and Certification that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances in NH.

2.1.97 Primary Care Provider (PCP)

2.1.97.1 "Primary Care Provider (PCP)" means a Participating Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the Continuity of Member Care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists (OB/GYNs), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All federal requirements applicable to primary care physicians shall also be applicable to PCPs as the term is used in this Agreement.

2.1.98 Prior Authorization

2.1.98.1 "Prior Authorization" means the process by which DHHS, the MCO, or another MCO participating in the MCM program, whichever is applicable, authorizes, in advance, the delivery of Covered Services based on factors, including but not limited to medical necessity, cost-effectiveness, and compliance with this Agreement.

2.1.99 Priority Population

2.1.99.1 "Priority Population" means a population that is most likely to have Care Management needs and be able to benefit from Care Management. The following groups are considered Priority Populations under this Agreement: Adults and Children with Special Health Care Needs, including, but not limited to, Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis, or with chronic pain; Members receiving services under HCBS waivers; Members identified as those with rising risk; individuals with

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high unmet resource needs; mothers of babies born with NAS; infants with NAS; pregnant women with Substance Use Disorder; intravenous drug users, including Members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use; individuals who have been in the ED for an overdose event in the last twelve (12) months; recently incarcerated individuals; individuals who have a suicide attempt in the last twelve (12) months and other Priority Populations as determined by the MCO and/or DHHS.

2.1.100 Program Start Date

2.1.100.1 "Program Start Date" means the date when the MCO is responsible for coverage of services to its Members in the MCM program, contingent upon Agreement approval by the Governor and Executive Council and DHHS's determination of successful completion of the Readiness Review period.

2.1.101 Provider

2.1.101.1 "Provider" means an individual medical, behavioral or social service professional, hospital, skilled nursing facility (SNF), other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

2.1.102 Provider Directory

2.1.102.1 "Provider Directory" means information on the MCO's Participating Providers for each of the Provider types covered under this Agreement, available in electronic form and paper form upon request to the Member in accordance with 42 CFR 438.10 and the terms of this Agreement.

2.1.103 Psychiatric Boarding

2.1.103.1 "Psychiatric Boarding" means a Member's continued physical presence in an emergency room or another temporary location after either completion of an Involuntary Emergency Admission (IEA) application, revocation of a conditional discharge, or commitment to New Hampshire Hospital or other designated receiving facility by a Court.

2.1.104 Qualified Bilingual/Multilingual Staff

2.1.104.1 "Qualified Bilingual/Multilingual Staff" means an employee of the MCO who is designated by the MCO to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the MCO that he or she is proficient in speaking and understanding spoken English and at

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least one (1) other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and is able to effectively, accurately, and impartially communicate directly with Members with LEP in their primary languages.

2.1.105 Qualified Interpreter for a Member with a Disability

2.1.105.1 "Qualified Interpreter for a Member with a Disability" means an interpreter who, via a remote interpreting service or an on-site appearance, adheres to generally accepted interpreter ethics principles, including Member confidentiality; and is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

2.1.105.2 Qualified interpreters can include, for example, sign language interpreters, oral transliterators (employees who represent or spell in the characters of another alphabet), and cued language transliterators (employees who represent or spell by using a small number of handshapes).

2.1.106 Qualified Interpreter for a Member with LEP

2.1.106.1 "Qualified Interpreter for a Member with LEP" means an interpreter who, via a remote interpreting service or an on-site appearance adheres to generally accepted interpreter ethics principles, including Member confidentiality; has demonstrated proficiency in speaking and understanding spoken English and at least one (1) other spoken language; and is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

2.1.107 Qualified Translator

2.1.107.1 "Qualified Translator" means a translator who adheres to generally accepted translator ethics principles, including Member confidentiality; has demonstrated proficiency in writing and understanding written English and at least one (1) other written language; and is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. [45 CFR 92.4, 92.201(d)-(e)]

2.1.108 Qualifying APM

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2.1.108.1 "Qualifying APM" means an APM approved by DHHS as consistent with the standards specified in this Agreement and in any subsequent DHHS guidance, including the DHHS Medicaid APM Strategy.

2.1.109 Recovery

2.1.109.1 "Recovery" means a process of change through which Members improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and Recovery support services for all populations.⁶

2.1.110 Referral Provider

2.1.110.1 "Referral Provider" means a Provider, who is not the Member's PCP, to whom a Member is referred for Covered Services.

2.1.111 Risk Scoring and Stratification

2.1.111.1 "Risk Scoring and Stratification" means the methodology to identify Members who are part of a Priority Population for Care Management and who should receive a Comprehensive Assessment. The MCO shall provide protocols to DHHS for review and approval on how Members are stratified by severity and risk level including details regarding the algorithm and data sources used to identify eligible Member for Care Management.

2.1.112 Rural Health Clinic (RHC)

2.1.112.1 "Rural Health Clinic (RHC)" means a clinic located in an area designated by DHHS as rural, located in a federally designated medically underserved area, or has an insufficient number of physicians, which meets the requirements under 42 CFR 491.

2.1.113 Second Opinion

2.1.113.1 "Second Opinion" means the opinion of a qualified health care professional within the Provider network, or the opinion of a Non-Participating Provider with whom the MCO has permitted the Member to consult, at no cost to the Member. [42 CFR 438.206(b)(3)]

2.1.114 Social Determinants of Health

2.1.114 "Social Determinants of Health" means a wide range of factors known to have an impact on healthcare, ranging from socioeconomic status, education and employment, to one's physical environment and access to healthcare.

⁶ SAMHSA, "Recovery and Recovery Support"

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2.1.115 State

2.1.115.1 The "State" means the State of New Hampshire and any of its agencies.

2.1.116 Subcontract

2.1.116.1 "Subcontract" means any separate contract or contract between the MCO and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the MCO is obligated to perform pursuant to this Agreement.

2.1.117 Subcontractor

2.1.117.1 "Subcontractor" means a person or entity that is delegated by the MCO to perform an administrative function or service on behalf of the MCO that directly or indirectly relates to the performance of all or a portion of the duties or obligations under this Agreement. A Subcontractor does not include a Participating Provider.

2.1.118 Substance Use Disorder

2.1.118.1 "Substance Use Disorder" means a cluster of symptoms meeting the criteria for Substance Use Disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th edition (2013), as described in He-W 513.02.

2.1.119 Substance Use Disorder Provider

2.1.119.1 "Substance Use Disorder Provider" means all Substance Use Disorder treatment and Recovery support service Providers as described in He-W 513.04.

2.1.120 Term

2.1.120.1 "Term" means the duration of this Agreement.

2.1.121 Third Party Liability (TPL)

2.1.121.1 "Third Party Liability (TPL)" means the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid State Plan.

2.1.121.2 By law, all other available third party resources shall meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

2.1.121.3 States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid State Plan.

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2.1.122 Transitional Care Management

2.1.122.1 "Transitional Care Management" means the responsibility of the MCO to manage transitions of care for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

2.1.122.2 The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

2.1.123 Transitional Health Care

2.1.123.1 "Transitional Health Care" means care that is available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

2.1.124 Transitional Home Care

2.1.124.1 "Transitional Home Care" means care that is available with a home care nurse, a licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or specialty care Provider or as part of the discharge plan.

2.1.125 Trauma Informed Care

2.1.125.1 "Trauma Informed Care" means a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for Recovery; recognizes the signs and symptoms of trauma in Members, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.⁷

2.1.126 Urgent, Symptomatic Office Visits

2.1.126.1 "Urgent, Symptomatic Office Visits" means office visits, available from the Member's PCP or another Provider within forty-eight (48) hours, for the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

⁷ SAMHSA, "Trauma Informed Approach and Trauma-Specific Interventions"

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2.1.127 Utilization Management

2.1.127.1 "Utilization Management" means the criteria of evaluating the necessity, appropriateness, and efficiency of Covered Services against established guidelines and procedures.

2.1.128 Value-Added Services

2.1.128.1 "Value-Added Services" means services not included in the Medicaid State Plan that the MCO elects to purchase and provide to Members at the MCO's discretion and expense to improve health and reduce costs. Value-Added Services are not included in capitation rate calculations.

2.1.129 Willing Provider

2.1.129.1 [Amendment #8]: "Willing Provider" means a Provider credentialed as a qualified treatment provider according to the requirements of DHHS and the MCO, who agrees to render services as authorized by the MCO and to comply with the terms of the MCO's Provider Agreement, including rates and policy manual.

2.2 Acronym List

- 2.2.1 AAP means American Academy of Pediatrics.
- 2.2.2 ABD means Acquired Brain Disorder.
- 2.2.3 ACT means Assertive Community Treatment.
- 2.2.4 ADA means Americans with Disabilities Act.
- 2.2.5 ADL means Activities of Daily Living.
- 2.2.6 ADT means Admission, Discharge and Transfer.
- 2.2.7 AIDS means Acquired Immune Deficiency Syndrome.
- 2.2.8 ANSA means Adult Needs and Strengths Assessment.
- 2.2.9 APM means Alternative Payment Model.
- 2.2.10 ARNP means Advanced Registered Nurse Practitioner.
- 2.2.11 ASAM means American Society of Addiction Medicine.
- 2.2.12 ASC means Accredited Standards Committee.
- 2.2.13 ASFRA means Assisted Suicide Funding Restriction Act.
- 2.2.14 ASL means American Sign Language.
- 2.2.15 BCPP means Breast and Cervical Cancer Program.

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- 2.2.16** [Amendment #7] ~~BHCTC means Behavioral Health Crisis Treatment Center.~~ Intentionally Left Blank.
- 2.2.17** CAHPS means Consumer Assessment of Healthcare Providers and Systems.
- 2.2.18** CANS means Child and Adolescent Needs and Strengths Assessment.
- 2.2.19** CAP means Corrective Action Plan.
- 2.2.20** CAPRSS means Council on Accreditation of Peer Recovery Support Services.
- 2.2.21** CARC means Claim Adjustment Reason Code.
- 2.2.22** CDT means Code on Dental Procedures and Nomenclature.
- 2.2.23** CEO means Chief Executive Officer.
- 2.2.24** CFI means Choices for Independence.
- 2.2.25** CFO means Chief Financial Officer.
- 2.2.26** CHIP means Children's Health Insurance Program.
- 2.2.27** CHIS means Comprehensive Health Care Information System.
- 2.2.28** CMH means Community Mental Health.
- 2.2.29** CMO means Chief Medical Officer.
- 2.2.30** CMR means Comprehensive Medication Review.
- 2.2.31** CMS means Centers for Medicare & Medicaid Services.
- 2.2.32** COB means Coordination of Benefits.
- 2.2.33** COBA means Coordination of Benefits Agreement.
- 2.2.34** CPT means Current Procedural Terminology.
- 2.2.35** CQI means Continuous Quality Improvement.
- 2.2.36** DBT means Dialectical Behavioral Therapy.
- 2.2.37** DCYF means New Hampshire Division for Children, Youth and Families.
- 2.2.38** DD means Developmental Disability.
- 2.2.39** DHHS means New Hampshire Department of Health and Human Services.
- 2.2.40** DME means Durable Medical Equipment.
- 2.2.41** DOB means Date of Birth.

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- 2.2.42** DOD means Date of Death.
- 2.2.43** DOJ means (New Hampshire or United States) Department of Justice.
- 2.2.44** DRA means Deficit Reduction Act.
- 2.2.45** DSM means Diagnostic and Statistical Manual of Mental Disorders.
- 2.2.46** DSRIP means The New Hampshire Delivery System Reform Incentive Payment Program.
- 2.2.47** DUR means Drug Utilization Review.
- 2.2.48** EBSE means Evidence-Based Supported Employment.
- 2.2.49** ECI means Elderly and Chronically Ill.
- 2.2.50** ED means Emergency Department.
- 2.2.51** EDI means Electronic Data Interchange.
- 2.2.52** EFT means Electronic Funds Transfer.
- 2.2.53** EOB means Explanation of Benefits.
- 2.2.54** EPSDT means Early and Periodic Screening, Diagnostic and Treatment.
- 2.2.55** EQR means External Quality Review.
- 2.2.56** EQRO means External Quality Review Organization.
- 2.2.57** ERISA means Employees Retirement Income Security Act of 1974.
- 2.2.58** EST means Eastern Standard Time.
- 2.2.59** ETL means Extract, Transformation and Load.
- 2.2.60** FAR means Federal Acquisition Regulation.
- 2.2.61** FCA means False Claims Act.
- 2.2.62** FDA means Food and Drug Administration for the United States Department of Health and Human Services.
- 2.2.63** FFATA means Federal Funding Accountability & Transparency Act.
- 2.2.64** FFS means Fee-for-Service.
- 2.2.65** FPL means Federal Poverty Level.
- 2.2.66** FQHC means Federally Qualified Health Center.
- 2.2.67** HCBS means Home and Community Based Services.
- 2.2.68** HCBS-I means Home and Community Based Services In Home Supports.

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- 2.2.69** HCPCS means Health Care Common Procedure Coding System.
 - 2.2.70** HHS means United States Department of Health and Human Services.
 - 2.2.71** HIPAA means Health Insurance Portability and Accountability Act.
 - 2.2.72** HIPP means Health Insurance Premium Payment.
 - 2.2.73** HITECH means Health Information Technology for Economic and Clinical Health Act of 2009.
 - 2.2.74** HIV means Human Immunodeficiency Virus.
 - 2.2.75** HMO means health maintenance organization.
 - 2.2.76** HRSA means Health Resources and Services Administration for the United States Department of Health and Human Services.
 - 2.2.77** I/T/U means Indian Tribe, Tribal Organization, or Urban Indian Organization.
 - 2.2.78** IADL means Instrumental Activities of Daily Living.
 - 2.2.79** IBNR means Incurred But Not Reported.
 - 2.2.80** ICF means Intermediate Care Facility.
 - 2.2.81** ID means Intellectual Disabilities.
 - 2.2.82** IDN means Integrated Delivery Network.
 - 2.2.83** IEA means Involuntary Emergency Admission.
 - 2.2.84** IHCP means Indian Health Care Provider.
 - 2.2.85** IHS means Indian Health Service.
 - 2.2.86** IMD means Institution for Mental Disease.
 - 2.2.87** IVR means Interactive Voice Response.
 - 2.2.88** LEP means Limited English Proficiency.
 - 2.2.89** LTSS means Long-Term Services and Supports.
 - 2.2.90** MACRA means Medicare Access and CHIP Reauthorization Act of 2015.
 - 2.2.91** MAT means Medication Assisted Treatment.
 - 2.2.92** MCIS means Managed Care Information System.
 - 2.2.93** MCM means Medicaid Care Management.
 - 2.2.94** MCO means Managed Care Organization.
 - 2.2.95** MED means Morphine Equivalent Dosing.

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- 2.2.96 MFCU means New Hampshire Medicaid Fraud Control Unit.
- 2.2.97 MLADCs means Masters Licensed Alcohol and Drug Counselors.
- 2.2.98 MLR means Medical Loss Ratio.
- 2.2.99 MMIS means Medicaid Management Information System.
- 2.2.100 NAS means Neonatal Abstinence Syndrome.
- 2.2.101 NCPDP means National Council for Prescription Drug Programs.
- 2.2.102 NCQA means National Committee for Quality Assurance.
- 2.2.103 NEMT means Non-Emergency Medical Transportation.
- 2.2.104 NH means New Hampshire.
- 2.2.105 NHID means New Hampshire Insurance Department.
- 2.2.106 NPI means National Provider Identifier.
- 2.2.107 NPES means National Plan and Provider Enumeration System.
- 2.2.108 OB/GYN means Obstetrics/Gynecology or Obstetricians/Gynecologists.
- 2.2.109 OIG means Office of the Inspector General for the United States Department of Health and Human Services.
- 2.2.110 OTP means Opioid Treatment Program.
- 2.2.111 PBM means Pharmacy Benefits Manager.
- 2.2.112 PCA means Personal Care Attendant.
- 2.2.113 PCP means Primary Care Provider.
- 2.2.114 PDL means Preferred Drug List.
- 2.2.115 PDMP means Prescription Drug Monitoring Program.
- 2.2.116 PHI means Protected Health Information.
- 2.2.117 PI means Personal Information.
- 2.2.118 PIP means Performance Improvement Project.
- 2.2.119 POS means Point of Service.
- 2.2.120 PRSS means Peer Recovery Support Services.
- 2.2.121 QAPI means Quality Assessment and Performance Improvement.
- 2.2.122 QOS means Quality of Service.
- 2.2.123 RARC means Reason and Remark Codes.

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- 2.2.124 RFP means Request for Proposal.
- 2.2.125 RHC means Rural Health Clinic.
- 2.2.126 SAMHSA means Substance Abuse and Mental Health Services Administration for the United States Department of Health and Human Services.
- 2.2.127 SBIRT means Screening, Brief Intervention, and Referral to Treatment.
- 2.2.128 SED means Serious Emotional Disturbance.
- 2.2.129 SHIP means State's Health Insurance Assistance Program.
- 2.2.130 SIU means Special Investigations Unit.
- 2.2.131 SMART means Specific, Measurable, Attainable, Realistic, and Time Relevant.
- 2.2.132 SMDL means State Medicaid Director Letter.
- 2.2.133 SMI means Severe Mental Illness.
- 2.2.134 SNF means Skilled Nursing Facility.
- 2.2.135 SPMI means Severe or Persistent Mental Illness.
- 2.2.136 SSADMf means Social Security Administration Death Master File.
- 2.2.137 SSAE means Statement on Standards for Attestation Engagements.
- 2.2.138 SSI means Supplemental Security Income.
- 2.2.139 SSN means Social Security Number.
- 2.2.140 TAP means Technical Assistance Publication.
- 2.2.141 TDD means Telecommunication Device for Deaf Persons.
- 2.2.142 TPL means Third Party Liability.
- 2.2.143 TTY means Teletypewriter.
- 2.2.144 UAT means User Acceptance Testing.
- 2.2.145 UDS means Urine Drug Screenings.
- 2.2.146 VA means United States Department of Veterans Affairs.

3 GENERAL TERMS AND CONDITIONS

3.1 Program Management and Planning

3.1.1 General

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3.1.1.1 The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to Members enrolled in the MCM program and who are enrolled in the MCO.

3.1.1.2 The MCO shall provide for all aspects of administrating and managing such program and shall meet all service and delivery timelines and milestones specified by this Agreement, applicable law or regulation incorporated directly or indirectly herein, or the MCM program.

3.1.2 Representation and Warranties

3.1.2.1 The MCO represents and warrants that it shall fulfill all obligations under this Agreement and meet the specifications as described in the Agreement during the Term, including any subsequently negotiated, and mutually agreed upon, specifications.

3.1.2.2 The MCO acknowledges that, in being awarded this Agreement, DHHS has relied upon all representations and warrants made by the MCO in its response to the DHHS Request for Proposal (RFP) attached hereto as Exhibit M, including any addenda, with respect to delivery of Medicaid managed care services and affirms all representations made therein.

3.1.2.3 The MCO represents and warrants that it shall comply with all of the material submitted to, and approved by DHHS as part of its Readiness Review. Any material changes to such approved materials or newly developed materials require prior written approval by DHHS before implementation.

3.1.2.4 The MCO shall not take advantage of any errors and/or omissions in the RFP or the resulting Agreement and amendments.

3.1.2.4.1 The MCO shall promptly notify DHHS of any such errors and/or omissions that are discovered.

3.1.2.5 This Agreement shall be signed and dated by all parties, and is contingent upon approval by Governor and Executive Council.

3.1.3 Program Management Plan

3.1.3.1 The MCO shall develop and submit a Program Management Plan for DHHS's review and approval.

3.1.3.2 The MCO shall provide the initial Program Management Plan to DHHS for review and approval at the beginning of the Readiness Review period; in future years, any modifications to the Program Management Plan shall be presented for prior approval to

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DHHS at least sixty (60) calendar days prior to the coverage year. The Program Management Plan shall:

3.1.3.2.1 Elaborate on the general concepts outlined in the MCO's Proposal and the section headings of the Agreement;

3.1.3.2.2 Describe how the MCO shall operate in NH by outlining management processes such as workflow, overall systems as detailed in the section headings of Agreement, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to Member and Provider experiences;

3.1.3.2.3 Describe how the MCO shall ensure timely notification to DHHS regarding:

3.1.3.2.3.1. Expected or unexpected interruptions or changes that impact MCO policy, practice, operations, Members or Providers,

3.1.3.2.3.2. Correspondence received from DHHS on emergent issues and non-emergent issues; and

3.1.3.2.4 Outline the MCO integrated organizational structure including NH-based resources and its support from its parent company, affiliates, or Subcontractors.

3.1.3.3 On an annual basis, the MCO shall submit to DHHS either a certification of "no change" to the Program Management Plan or a revised Program Management Plan together with a redline that reflects the changes made to the Program Management Plan since the last submission.

3.1.4 Key Personnel Contact List

3.1.4.1 The MCO shall submit a Key Personnel Contact List to DHHS that includes the positions and associated information indicated in Section 3.15.1 (Key Personnel) of this Agreement at least sixty (60) calendar days prior to the scheduled start date of the MCM program.

3.1.4.2 Thereafter, the MCO shall submit an updated Contact List immediately upon any Key Personnel staff changes.

3.2 Agreement Elements

3.2.1 The Agreement between the parties shall consist of the following:

3.2.1.1 General Provisions, Form Number P-37

3.2.1.2 Exhibit A: Scope of Services.

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- 3.2.1.3 Exhibit B: Method and Conditions Precedent to Payment
- 3.2.1.4 Exhibit C: Special Provisions
- 3.2.1.5 Exhibit C-1: Revisions to General Provisions
- 3.2.1.6 Exhibit D: Certification Regarding Drug Free Workplace Requirements
- 3.2.1.7 Exhibit E: Certification Regarding Lobbying
- 3.2.1.8 Exhibit F: Certification Regarding Debarment, Suspension, and Other Responsibility Matters
- 3.2.1.9 Exhibit G: Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections
- 3.2.1.10 Exhibit H: Certification Regarding Environmental Tobacco Smoke
- 3.2.1.11 Exhibit I: Health Insurance Portability Act Business Associate
- 3.2.1.12 Exhibit J: Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.
- 3.2.1.13 Exhibit K: DHHS Information Security Requirements.
- 3.2.1.14 Exhibit L: MCO Implementation Plan
- 3.2.1.15 Exhibit M: MCO Proposal submitted in response to RFP-2019-OMS-02-MANAG, by reference.
- 3.2.1.16 Exhibit N: Liquidated Damages Matrix
- 3.2.1.17 Exhibit O: Quality and Oversight Reporting Requirements
- 3.2.1.18 Exhibit P: MCO Program Oversight Plan

3.3 Conflicts Between Documents

3.3.1 In the event of any conflict or contradiction between or among the documents which comprise the Agreement, as listed in Section 3.2 (Agreement Elements) above, the documents shall control in the order of precedence as follows:

- 3.3.1.1 First: P-37, Exhibit A Scope of Services, Exhibit B Method and Conditions Precedent to Payment, Exhibit C Special Provisions and Exhibit C-1 Revisions to General Provisions, Exhibit N Liquidated Damages Matrix, Exhibit O Quality and Oversight Reporting Requirements

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3.3.1.2 Second: Exhibit I Health Insurance Portability Act Business Associate and Exhibit K DHHS Information Security Requirements

3.3.1.3 Third: Exhibits D through H, Exhibit J, and Exhibit L, Exhibit P, Exhibit M.

3.4 Delegation of Authority

3.4.1 Whenever, by any provision of this Agreement, any right, power, or duty is imposed or conferred on DHHS, the right, power, or duty so imposed or conferred is possessed and exercised by the Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of the DHHS and NHID.

3.5 Authority of the New Hampshire Insurance Department

3.5.1 Pursuant to this Agreement and under the laws and rules of the State, the NHID shall have authority to regulate and oversee the licensing requirements of the MCO to operate as a health maintenance organization (HMO) in the State of New Hampshire.

3.5.2 The MCO is subject to all applicable laws and rules (and as subsequently amended) including but not limited to RSA 420-B; Managed Care Law and Rules RSA. 420-J; and Admin Rules 2700; compliance with Bulletin INSNO. 12-015-AB, and further updates made by the NHID; and the NH Comprehensive Health Care Information System (CHIS) data reporting submission under NHID rules/bulletins.

3.6 Time of the Essence

3.6.1 In consideration of the need to ensure uninterrupted and continuous services under the MCM program, time is of the essence in the performance of the MCO's obligations under the Agreement.

3.7 CMS Approval of Agreement and Any Amendments

3.7.1 This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to and contingent upon the approval of CMS.

3.7.2 This Agreement submission shall be considered complete for CMS's approval if:

3.7.2.1 All pages, appendices, attachments, etc. were submitted to CMS; and

3.7.2.2 Any documents incorporated by reference (including but not limited to State statute, regulation, or other binding document,

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such as a Member Handbook) to comply with federal regulations and the requirements of this review tool were submitted to CMS.

3.7.3 As part of this Agreement, DHHS shall submit to CMS for review and approval the MCO rate certifications concurrent with the review and approval process for this Agreement. [42 CFR 438.7(a)]

3.7.4 DHHS shall also submit to CMS for review and approval any Alternative Payment arrangements or other Provider payment arrangement initiatives based on DHHS's description of the initiatives submitted and approved outside of the Agreement. [42 CFR 438.6(c)]

3.8 Cooperation With Other Vendors and Prospective Vendors

3.8.1 This is not an exclusive Agreement and DHHS may award simultaneous and/or supplemental contracts for work related to the Agreement, or any portion thereof. The MCO shall reasonably cooperate with such other vendors, and shall not knowingly or negligently commit or permit any act that may interfere with the performance of work by any other vendor, or act in any way that may place Members at risk.

3.8.2 The MCO is required to notify DHHS within twelve (12) hours of a report by a Member, Member's relative, guardian or authorized representative of an allegation of a serious criminal offense against the Member by any employee of the MCO, its subcontractor or a Provider.

3.8.2.1 For the purpose of this Agreement, a serious criminal offense should be defined to include murder, arson, rape, sexual assault, assault, burglary, kidnapping, criminal trespass, or attempt thereof.

3.8.3 The MCO's notification shall be to a member of senior management of DHHS such as the Commissioner, Deputy Commissioner, Associate Commissioner, Medicaid Director, or Deputy Medicaid Director.

3.9 Renegotiation and Re-Procurement Rights

3.9.1 Renegotiation of Agreement

3.9.1.1 Notwithstanding anything in the Agreement to the contrary, DHHS may at any time during the Term exercise the option to notify the MCO that DHHS has elected to renegotiate certain terms of the Agreement.

3.9.1.2 Upon the MCO's receipt of any notice pursuant to this Section 3.9 (Renegotiation and Re-Procurement Rights) of the Agreement, the MCO and DHHS shall undertake good faith negotiations of the subject terms of the Agreement, and may execute

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an amendment to the Agreement subject to approval by Governor and Executive Council.

3.9.2 Re-Procurement of the Services or Procurement of Additional Services

3.9.2.1 Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected MCO's services and/or deliverables provided during any period of the Agreement, DHHS may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the scope of work covered by the Agreement or scope of work similar or comparable to the scope of work performed by the MCO under the Agreement.

3.9.2.2 DHHS shall give the MCO ninety (90) calendar days' notice of intent to replace another MCO participating in the MCM program or to add an additional MCO or other contractors to the MCM program.

3.9.2.3 If, upon procuring the services or deliverables or any portion of the services or deliverables from a Subcontractor in accordance with this section, DHHS, in its sole discretion, elects to terminate this Agreement, the MCO shall have the rights and responsibilities set forth in Section 7 (Termination of Agreement) and Section 5.7 (Dispute Resolution Process).

3.10 Organization Requirements

3.10.1 General Organization Requirements

3.10.1.1 As a condition to entering into this Agreement, the MCO shall be licensed by the NHID to operate as an HMO in the State as required by RSA 420-B, and shall have all necessary registrations and licensures as required by the NHID and any relevant State and federal laws and regulations.

3.10.1.2 As a condition to entering into this Agreement, and during the entire Agreement Term, the MCO shall ensure that its articles of incorporation and bylaws do not prohibit it from operating as an HMO or performing any obligation required under this Agreement.

3.10.1.3 The MCO shall not be located outside of the United States. [42 CFR 438.602(i)] The MCO is prohibited from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories.

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3.10.1.4 [Amendment #9][Amendment #8:] At the Department's discretion, the MCO shall initiate Centers for Medicare and Medicaid defined notification processes and application as may be appropriate to effectuate an integrated Medicare Advantage Duals-Special Needs Plan (D-SNP) targeting a beneficiary effective date at a date to be determined of January 1, 2024.

3.10.2 Articles

3.10.2.1 The MCO shall provide, by the beginning of each Agreement year and at the time of any substantive changes, written assurance from MCO's legal counsel that the MCO is not prohibited by its articles of incorporation from performing the services required under this Agreement.

3.10.3 Ownership and Control Disclosures

3.10.3.1 The MCO shall submit to DHHS the name of any persons or entities with an ownership or control interest in the MCO that:

3.10.3.1.1 Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the MCO's equity;

3.10.3.1.2 Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the MCO if that interest equals at least five percent (5%) of the value of the MCO's assets; or

3.10.3.1.3 Is an officer or director of an MCO organized as a corporation or is a partner in an MCO organized as a partnership. [Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]

3.10.3.2 The submission shall include for each person or entity, as applicable:

3.10.3.2.1 The address, including the primary business address, every business location, and P.O. Box address, for every entity;

3.10.3.2.2 The date of birth (DOB) and social security number (SSN) of any individual;

3.10.3.2.3 Tax identification number(s) of any corporation;

3.10.3.2.4 Information on whether an individual or entity with an ownership or control interest in the MCO is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

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3.10.3.2.5 Information on whether a person or corporation with an ownership or control interest in any Subcontractor in which the MCO has a five percent (5%) or more interest is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

3.10.3.2.6 The name of any other disclosing entity, as such term is defined in 42 CFR 455.101, in which an owner of the MCO has an ownership or control interest;

3.10.3.2.7 The name, address, DOB, and SSN of any managing employee of the MCO, as such term is defined by 42 CFR 455.101; and

3.10.3.2.8 Certification by the MCO's CEO that the information provided in this Section 3.10.3 (Ownership and Control Disclosures) to DHHS is accurate to the best of his or her information, knowledge, and belief.

3.10.3.3 The MCO shall disclose the information set forth in this Section 3.10.3 (Ownership and Control Disclosures) on individuals or entities with an ownership or control interest in the MCO to DHHS at the following times:

3.10.3.3.1 At the time of Agreement execution;

3.10.3.3.2 When the Provider or disclosing entity submits a Provider application;

3.10.3.3.3 When the Provider or disclosing entity executes a Provider agreement with DHHS;

3.10.3.3.4 Upon request of DHHS during the revalidation of the Provider enrollment; and

3.10.3.3.5 Within thirty-five (35) calendar days after any change in ownership of the disclosing entity. [Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 103; 42 CFR 455.104(c)(1) and (4)]

3.10.3.4 DHHS shall review the ownership and control disclosures submitted by the MCO and any Subcontractors. [42 CFR 438.602(c); 42 CFR 438.608(c)]

3.10.3.5 The MCO shall be fined in accordance with Exhibit N (Liquidated Damages Matrix) for any failure to comply with ownership disclosure requirements detailed in this Section.

3.10.4 Change in Ownership or Proposed Transaction

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3.10.4.1 The MCO shall inform DHHS and the NHID of its intent to merge with or be acquired, in whole or in part, by another entity or another MCO or of any change in control within seven (7) calendar days of a management employee learning of such intent. The MCO shall receive prior written approval from DHHS and the NHID prior to taking such action.

3.10.5 Prohibited Relationships

3.10.5.1 Pursuant to Section 1932(d)(1)(A) of the Social Security Act (42 USC 1396u-2(d)(1)(A)), the MCO shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the MCO's equity who has been, or is affiliated with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(c)(2); Exec. Order No. 12549]

3.10.5.2 The MCO shall not have an employment, consulting, or any other contractual agreement or engage a Subcontractor, vendor or Provider who is a Sanctioned Individual or entity. In accordance with Section 1128(b)(8) of the Social Security Act, a Sanctioned Individual means a person who:

3.10.5.2.1 Has a direct or indirect ownership or control interest of 5 percent (5%) or more in the entity, and:

3.10.5.2.1.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.1.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.1.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.2 Has an ownership or control interest (as defined in Section 1124(a)(3) of the Social Security Act) in the entity, and:

3.10.5.2.2.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled

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substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.2.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.2.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.3 Is an officer, director, agent, or managing employee of the MCO, and:

3.10.5.2.3.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud, or

3.10.5.2.3.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.3.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.4 No longer has direct or indirect ownership or control interest of 5 percent (5%) or more in the MCO or no longer has an ownership or control interest defined under Section 1124(a)(3) of the Social Security Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who:

3.10.5.2.4.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.4.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.4.3. Has been excluded from participation under a program under title XVIII or under a state health care program. [Section 1128(b)(8) of the Social Security Act]

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3.10.5.3 The MCO shall retain any data, information, and documentation regarding the above described relationships for a period of no less than ten (10) years.

3.10.5.4 Within five (5) calendar days of discovery, the MCO shall provide written disclosure to DHHS, and Subcontractors shall provide written disclosure to the MCO, which shall provide the same to DHHS, of any individual or entity (or affiliation of the individual or entity) who/that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or prohibited affiliation under 42 CFR 438.610. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.608(c)(1); 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(b); 42 CFR 438.610(c)(1) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549]

3.10.5.5 If DHHS learns that the MCO has a prohibited relationship with an individual or entity that (i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the MCO has relationship with an individual who is an affiliate of such an individual; (ii) is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act, DHHS may:

3.10.5.5.1 Terminate the existing Agreement with the MCO;

3.10.5.5.2 Continue an existing Agreement with the MCO unless the HHS Secretary directs otherwise;

3.10.5.5.3 Not renew or extend the existing Agreement with the MCO unless the HHS Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliation. [42 CFR 438.610(d)(2)-(3); 42 CFR 438.610(a); 42 CFR 438.610(b); Exec. Order No. 12549]

3.10.6 Background Checks and Screenings

3.10.6.1 The MCO shall perform criminal history record checks on its owners, directors, and managing employees, as such terms are defined in 42 CFR Section 455.101 and clarified in applicable

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subregulatory guidance such as the Medicaid Provider Enrollment Compendium.

3.10.6.2 [Amendment #8:] The MCO or its Subcontractors shall conduct ~~monthly~~ background checks upon hire and monthly on all ~~directors, officers, employees (or contractors and their employees) contractors or Subcontractors~~ to ensure that the MCO and Subcontractors ~~it does not~~ employ or contract with any individual or entity:

3.10.6.2.1 Convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act;

3.10.6.2.2 Debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and/or

3.10.6.2.3 Is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act. [[42 CFR 438.808(a); 42 CFR 438.808(b)(1); 42 CFR 431.55(h); section 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; SMDL #09-001; 76 Fed. Reg. 5862, 5897 (February 2, 2011)]

3.10.6.3 [Amendment #8:] In addition, the MCO, or its Subcontractor shall conduct screenings upon hire and monthly of its employees (except its directors and officers), and contractors and MCO Subcontractors' contractor employees (except its directors and officers) to ensure that none of them appear on: ~~In addition, the MCO shall conduct screenings of its directors, officers, employees, and contractors and Subcontractors to ensure that none of them appear on:~~

3.10.6.3.1 HHS-OIG's List of Excluded Individuals/Entities;

3.10.6.3.2 [Amendment #8:] The System of Award Management; and

3.10.6.3.3 [Amendment #8:] Intentionally left blank ~~The Social Security Administration Death Master File;~~

3.10.6.3.4 [Amendment #8:] The list maintained by the Office of Foreign Assets Control; and~~er~~

3.10.6.3.5 To the extent applicable, NPPES (collectively, these lists are referred to as the "Exclusion Lists").

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~~3.10.6.4 [Amendment #8:] Intentionally left blank The MCO shall conduct screenings of all of its directors, officers, employees and Subcontractors monthly to ensure that none of the foregoing appear on any of the Exclusion Lists and that it continues to comply with Section 3.10.3 (Ownership and Control Disclosures) above. [SMDL #09-001; 76 Fed. Reg. 5862, 5897 (February 2, 2011)]~~

~~3.10.6.5 [Amendment #8:] The MCO shall certify to DHHS annually that it or its Subcontractors performs screenings upon hire and monthly thereafter against the Exclusion Lists and that neither the MCO nor its Subcontractors, including contractor employees of MCO Subcontractors, have any employees, directly or indirectly, with: The MCO shall certify to DHHS annually that it performs monthly screenings against the Exclusion Lists and that it does not have any director or officer or employ or contract, directly or indirectly, with:~~

~~3.10.6.5.1 Any individual or entity excluded from participation in the federal health care program;~~

~~3.10.6.5.2 Any entity for the provision of such health care, utilization review, medical social work, or administrative services through an excluded individual or entity or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;~~

~~3.10.6.5.3 Any individual or entity excluded from Medicare, Medicaid or NH participation by DHHS per the DHHS system of record;~~

~~3.10.6.5.4 Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act; and/or~~

~~3.10.6.5.5 Any individual entity appearing on any of the Exclusion Lists.~~

~~3.10.6.6 [Amendment #8:] In the event that the MCO or its Subcontractor identifies that it has employed or contracted with a person or entity which would make the MCO unable to certify as required under this Section 3.10.6 (Background Checks and Screenings) or Section 3.10.3 (Ownership and Control Disclosures) above, then the MCO should notify DHHS in writing and shall begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved waiver program.~~

~~3.10.6.7 [Amendment #8:] The MCO shall maintain documentation to ensure screenings have been completed by Subcontractors and reviewed by the MCO monthly.~~

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3.10.7 Conflict of Interest

3.10.7.1 The MCO shall ensure that safeguards, at a minimum equal to federal safeguards (41 USC 423, Section 27), are in place to guard against conflict of interest. [Section 1923(d)(3) of the Social Security Act; SMDL 12/30/97]. The MCO shall report transactions between the MCO and parties in interest to DHHS and any other agency as required, and make it available to MCO Members upon reasonable request. [Section 1903(m)(4)(B) of the Social Security Act]

3.10.7.2 The MCO shall report to DHHS and, upon request, to the HHS Secretary, the HHS Inspector General, and the Comptroller General a description of transactions between the MCO and a party in interest (as defined in Section 1318(b) of the Social Security Act), including the following transactions:

3.10.7.2.1 Any sale or exchange, or leasing of any property between the MCO and such a party;

3.10.7.2.2 Any furnishing for consideration of goods, services (including management services), or facilities between the MCO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and

3.10.7.2.3 Any lending of money or other extension of credit between the MCO and such a party. [Section 1903(m)(4)(A) of the Social Security Act; Section 1318(b) of the Social Security Act]

3.11 Confidentiality

3.11.1 Confidentiality of DHHS Information and Records

3.11.1.1 All information, reports, and records maintained hereunder or collected in connection with the performance of the services under the Agreement shall be confidential and shall not be disclosed by the MCO; provided however, that pursuant to State rules, State and federal laws and the regulations of DHHS regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Agreement; and provided further, that the use or disclosure by any party of any information concerning a Member for any purpose not directly connected with the administration of DHHS or the MCO's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his or her attorney or guardian.

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3.11.2 Request to DHHS of MCO Confidential or Proprietary Data or Information

3.11.2.1 DHHS may, in the course of carrying out its responsibilities under this Agreement, have or gain access to confidential or proprietary data or information owned or maintained by the MCO.

3.11.2.2 Insofar as the MCO seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the MCO shall clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential.

3.11.2.3 The MCO acknowledges that DHHS is subject to the Right-to-Know Law, RSA Chapter 91-A.

3.11.2.4 DHHS shall maintain the confidentiality of the identified Confidential Information insofar as it is consistent with applicable laws, rules, or regulations, including but not limited to RSA Chapter 91-A.

3.11.2.5 In the event DHHS receives a request for the information identified by the MCO as confidential, DHHS shall notify the MCO in writing and specify the date DHHS intends to release the requested information.

3.11.2.6 Any effort to prohibit or enjoin the release of the information shall be the MCO's responsibility and at the MCO's sole expense.

3.11.2.7 If the MCO fails to obtain a valid and enforceable court order in the State of New Hampshire enjoining the disclosure of the requested information within fifteen (15) business days of DHHS's written notification, DHHS may release the information on the date DHHS specified in its notice to the MCO without incurring any liability to the MCO.

3.12 Privacy and Security of Members' Information

3.12.1 The MCO shall be in compliance with privacy and security policies established by State or federal law, regulations or guidelines, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and their respective implementing regulations, federal statutes and regulations governing the privacy of Substance Use Disorder patient records (42 CFR, Part 2), and all applicable State statutes, rules and regulations including, but not limited to, RSA 167:30.

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3.12.2 The MCO shall protect the confidentiality of all DHHS records with identifying medical information in them. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(ii)]

3.12.3 The MCO shall execute as part of this Agreement, a Business Associate Agreement, as such term is defined by HIPAA, and the DHHS information security requirements as outlined in Exhibit I (HIPAA Business Associate Agreement), governing the permitted uses, disclosure and security of Protected Health Information (PHI), as such term is defined by HIPAA, and as provided by DHHS to the MCO.

3.12.4 The MCO shall ensure that if Member Substance Use Disorder records or data protected by 42 CFR Part 2 are created, maintained, or disclosed, any record or data shall be safeguarded according to the requirements found in 42 CFR Part 2, and that Member consent is obtained as required by 42 CFR Part 2.

3.12.5 The MCO shall ensure that it secures and protects the State and DHHS data when such data resides on the MCO's network, when in transit, and while stored and cached.

3.12.6 State and DHHS data shall be encrypted while in transit.

3.12.7 The MCO shall ensure that it secures and protects DHHS data if any DHHS data or Member records or data are transmitted by fax, and shall ensure that appropriate notices relating to confidentiality or erroneous transmission are used with each fax transmission.

3.12.8 With the exception of submission to the CHIS or other requirements of State or federal law or the terms of this Agreement, claims and Member data on NH Medicaid Members may not be released to any party without the express written consent of DHHS.

3.12.9 The MCO shall maintain written policies and procedures ensuring compliance with this Section 3.12 (Privacy and Security of Members' Information), which shall be available to DHHS upon request.

3.12.10 In the event that the MCO or one of its Subcontractors had a breach, as such term is defined by HIPAA, or had an unauthorized disclosure of State or DHHS data, the MCO shall notify DHHS within two (2) hours of knowledge that such breach or unauthorized disclosure has been confirmed. Failure to adequately protect Member information, DHHS claims, and other data may subject the MCO to sanctions and/or the imposition of liquidated damages in accordance with Section 5.5.2 (Liquidated Damages).

3.13 Compliance With State and Federal Laws

3.13.1 General Requirements

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3.13.1.1 [Amendment #10:] The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.13 (Compliance with State and Federal Laws), and any laws, regulations or administrative rules effective after the execution of this Agreement. The MCO shall comply with any applicable federal and State laws that pertain to Member rights and ensure that its employees and Participating Providers observe and protect those rights. [42 CFR 438.100(a)(2)]

3.13.1.2 The MCO shall comply, at a minimum, with the following:

3.13.1.2.1 Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. Section 1395 et seq.; Related rules: Title 42 Chapter IV;

3.13.1.2.2 Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. Section 1396 et seq. (specific to managed care: Section 1902(a)(4), 1903(m), 1905(t), and 1932 of the SSA); Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR Section 438; see also 431 and 435);

3.13.1.2.3 CHIP: Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397; Regulations promulgated thereunder: 42 CFR 457;

3.13.1.2.4 Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;

3.13.1.2.5 State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;

3.13.1.2.6 State administrative rules and laws pertaining to confidentiality;

3.13.1.2.7 American Recovery and Reinvestment Act;

3.13.1.2.8 Title VI of the Civil Rights Act of 1964;

3.13.1.2.9 The Age Discrimination Act of 1975;

3.13.1.2.10 The Rehabilitation Act of 1973;

3.13.1.2.11 Title IX of the Education Amendments of 1972 (regarding education programs and activities);

3.13.1.2.12 The ADA;

3.13.1.2.13 42 CFR Part 2; and

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3.13.1.2.14 Section 1557 of the Affordable Care Act. [42 CFR 438.3(f)(1); 42 CFR 438.100(d)]

3.13.1.3 [Amendment #10:] The MCO shall comply with all aspects of the DHHS Sentinel Event Reporting and Review Policy ~~PR-10-01, effective September 2010~~ PO.1003, and any subsequent versions and/or amendments;

3.13.1.3.1' [Amendment #10:] The MCO shall 1) cooperate with review of any reported any investigation of a Ssentinel event, including involvement in the Sentinel Event Review team, and provide any additional reporting information requested by DHHS, and 2) participate in a DHHS sentinel event review, if requested to conduct the Sentinel Event Review;

3.13.1.3.2 The MCO shall report to DHHS within twenty-four (24) hours any time a sentinel event occurs with one of its Members. This does not replace the MCO's responsibility to notify the appropriate authority if the MCO suspects a crime has occurred;

3.13.1.3.3 The MCO shall comply with all statutorily mandated reporting requirements, including but not limited to, RSA 161-F:42-54 and RSA 169-C:29;

3.13.1.3.4 In instances where the time frames detailed in the Agreement conflict with those in the DHHS Sentinel Event Policy, the policy requirements will prevail.

3.13.2 Non-Discrimination

3.13.2.1 The MCO shall require Participating Providers and Subcontractors to comply with the laws listed in Section 3.13.1 (General Requirements) above, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. [42 CFR 438.3(d)(4)]

3.13.3 Reporting Discrimination Grievances

3.13.3.1 The MCO shall forward to DHHS copies of all grievances alleging discrimination against Members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability or

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gender identity for review and appropriate action within three (3) business days of receipt by the MCO.

3.13.3.2 Failure to submit any such grievance within three (3) business days may result in the imposition of liquidated damages as outlined in Section 5.5.2. (Liquidated Damages).

3.13.4 Americans with Disabilities Act

3.13.4.1 The MCO shall have written policies and procedures that ensure compliance with requirements of the ADA, and a written plan to monitor compliance to determine the ADA requirements are being met.

3.13.4.2 The ADA compliance plan shall be sufficient to determine the specific actions that shall be taken to remove existing barriers and/or to accommodate the needs of Members who are qualified individuals with a disability.

3.13.4.3 The ADA compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all Members who are qualified individuals with a disability, including but not limited to street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

3.13.4.4 A "Qualified Individual with a Disability," defined pursuant to 42 U.S.C. Section 12131(2), is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of Auxiliary Aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

3.13.4.5 The MCO shall require Participating Providers and Subcontractors to comply with the requirements of the ADA. In providing Covered Services, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid Members who are qualified individuals with disabilities covered by the provisions of the ADA.

3.13.4.6 The MCO shall survey Participating Providers of their compliance with the ADA using a standard survey document that shall be provided by DHHS. Completed survey documents shall be kept on file by the MCO and shall be available for inspection by DHHS.

3.13.4.7 The MCO shall, in accordance with Exhibit G (Certification Regarding ADA Compliance), annually submit to DHHS a written

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certification that it is conversant with the requirements of the ADA, that it is in compliance with the ADA, that it has complied with this Section 3.13.4 (Americans with Disabilities Act) of the Agreement, and that it has assessed its Participating Provider network and certifies that Participating Providers meet ADA requirements to the best of the MCO's knowledge.

3.13.4.8 The MCO warrants that it shall hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the MCO to be in compliance with the ADA.

3.13.4.9 Where applicable, the MCO shall abide by the provisions of Section 504 of the Federal Rehabilitation Act of 1973, as amended, 29 U.S.C. Section 794, regarding access to programs and facilities by people with disabilities.

3.13.5 Non-Discrimination in Employment

3.13.5.1 The MCO shall not discriminate against any employee or applicant for employment because of age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

3.13.5.2 The MCO shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

3.13.5.3 Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship.

3.13.5.4 The MCO agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

3.13.5.5 The MCO shall, in all solicitations or advertisements for employees placed by or on behalf of the MCO, state that all qualified applicants shall receive consideration for employment without regard to age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

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3.13.5.6 The MCO shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other agreement or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of the MCO's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.13.5.7 The MCO shall comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.13.5.8 The MCO shall furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and shall permit access to its books, records, and accounts by DHHS and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.13.5.9 The MCO shall include the provisions described in this Section 3.13.5 (Non-Discrimination in Employment) in every contract with a Subcontractor or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions shall be binding upon each Subcontractor or vendor.

3.13.5.10 The MCO shall take such action with respect to any contract with a Subcontractor or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance, provided, however, that in the event the MCO becomes involved in, or is threatened with, litigation with a Subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

3.13.6 Non-Compliance

3.13.6.1 In the event of the MCO's noncompliance with the non-discrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated or suspended in whole or in part and the MCO may be declared ineligible for further government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24,

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1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.13.7 Changes in Law

3.13.7.1 The MCO shall implement appropriate program, policy or system changes, as required by changes to State and federal laws or regulations or interpretations thereof.

3.14 Subcontractors

3.14.1 MCO Obligations

3.14.1.1 The MCO shall maintain ultimate responsibility for adhering to, and otherwise fully complying with the terms and conditions of this Agreement, notwithstanding any relationship the MCO may have with the Subcontractor, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by the MCO.

3.14.1.2 For the purposes of this Agreement, such work performed by any Subcontractor shall be deemed performed by the MCO. [42 CFR 438.230(b)]

3.14.1.3 DHHS reserves the right to require the replacement of any Subcontractor or other contractor found by DHHS to be unacceptable or unable to meet the requirements of this Agreement, and to object to the selection or use of a Subcontractor or contract.

3.14.1.4 The MCO, regardless of its written agreements with any Subcontractors, maintains ultimate responsibility for complying with this Agreement.

3.14.1.5 The MCO shall have oversight of all Subcontractors' policies and procedures for compliance with the False Claims Act (FCA) and other State and federal laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

3.14.2 Contracts with Subcontractors

3.14.2.1 The MCO shall have a written agreement between the MCO and each Subcontractor which includes, but shall not be limited to:

3.14.2.1.1 All required activities and obligations of the Subcontractor and related reporting responsibilities and safeguarding of Confidential Information according to State rules, and State and federal laws;

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3.14.2.1.2 Full disclosure of the method and amount of compensation or other consideration received by the Subcontractor;

3.14.2.1.3 Amount, duration, and scope of services to be provided by the Subcontractor;

3.14.2.1.4 Term of the agreement, methods of extension, and termination rights;

3.14.2.1.5 The process to transition services when the agreement expires or terminates;

3.14.2.1.6 Information about the grievance and appeal system and the rights of the Member as described in 42 CFR 438.414 and 42 CFR 438.10(g);

3.14.2.1.7 Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement;

3.14.2.1.8 Requirements for the Subcontractor:

3.14.2.1.8.1. To hold harmless DHHS and its employees, and all Members served under the terms of this Agreement in the event of non-payment by the MCO;

3.14.2.1.8.2. To indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors;

3.14.2.1.9 Requirements that provide that:

3.14.2.1.9.1. The MCO, DHHS, NH Medicaid Fraud Control Unit (MFCU), NH Department of Justice (DOJ), U.S. DOJ, the OIG, and the Comptroller General or their respective designees shall have the right to audit, evaluate, and inspect, and that it shall make available for the purpose of audit, evaluation or inspection, any premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of the services and/or activities performed or determination of amounts payable under

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this Agreement; [42 CFR 438.230(c)(3)(i) & (ii); 42 CFR 438.3(k)]

3.14.2.1.9.2. The Subcontractor shall further agree that it can be audited for ten (10) years from the final date of the Term or from the date of any completed audit, whichever is later; and [42 CFR 438.230(c)(3)(iii); 42 CFR 438.3(k)]

3.14.2.1.9.3. The MCO, DHHS, MFCU, NH DOJ, U.S. DOJ, OIG, and the Comptroller General or their respective designees may conduct an audit at any time if DHHS, MFCU, NH DOJ, U.S. DOJ, the OIG, and the Comptroller General or their respective designee determines that there is a reasonable possibility of fraud, potential Member harm or similar risk. [42 CFR 438.230(c)(3)(iv); 42 CFR 438.3(k)]

3.14.2.1.10 Subcontractor's agreement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority;

3.14.2.1.11 Require Subcontractor to submit ownership and controlling interest information as required by Section 3.10.3 (Ownership and Control Disclosures);

3.14.2.1.12 Require Subcontractors to investigate and disclose to the MCO, at contract execution or renewal, and upon request by the MCO of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid since the inception of those programs and who is [42 CFR 455.106(a)]:

3.14.2.1.12.1. A person who has an ownership or control interest in the Subcontractor or Participating Provider; [42 CFR 455.106(a)(1)]

3.14.2.1.12.2. An agent or person who has been delegated the authority to obligate or act on behalf of the Subcontractor or Participating Provider; or [42 CFR 455.101; 42 CFR 455.106(a)(1)]

3.14.2.1.12.3. An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the Subcontractor or

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Participating Provider [42 CFR 455.101; 42 CFR 455.106(a)(2)]

3.14.2.1.13 Require Subcontractor to screen its directors, officers, employees, contractors and Subcontractors against each of the Exclusion Lists on a monthly basis and report to the MCO any person or entity appearing on any of the Exclusion Lists and begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved waiver program;

3.14.2.1.14 Require Subcontractor to have a compliance plan that meets the requirements of 42 CFR Section 438.608 and policies and procedures that meet the Deficit Reduction Act (DRA) of 2005 requirements;

3.14.2.1.15 Prohibit Subcontractor from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories;

3.14.2.1.16 A provision for revoking delegation of activities or obligations, or imposing other sanctions if the Subcontractor's performance is determined to be unsatisfactory by the MCO or DHHS;

3.14.2.1.17 Subcontractor's agreement to comply with the ADA, as required by Section 3.13.4 (Americans with Disabilities Act) above;

3.14.2.1.18 Include provisions of this Section 3.14.2 (Contracts with Subcontractors) in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965;

3.14.2.1.19 Require any Subcontractor, to the extent that the Subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under this Agreement, to implement policies and procedures, as reviewed by DHHS, for reporting of all Overpayments identified, including embezzlement or receipt of Capitation Payments to which it was not entitled or recovered, specifying the Overpayments due to potential fraud, to the State.

3.14.2.1.20 Require any Subcontractor to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and Agreement provisions. [42 CFR 438.230(c)(2); 42 CFR 438.3(k)]

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3.14.2.1.21 Require any Subcontractor to comply with any other provisions specifically required under this Agreement or the applicable requirements of 42 CFR 438. [42 CFR 438.230]

3.14.2.2 The MCO shall notify DHHS in writing within one (1) business day of becoming aware that its Subcontractor is cited as non-compliant or deficient by any State or federal regulatory authority.

3.14.2.3 If any of the MCO's activities or obligations under this Agreement are delegated to a Subcontractor:

3.14.2.3.1 The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the MCO and the Subcontractor; and

3.14.2.3.2 The contract or written arrangement between the MCO and the Subcontractor shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the state or the MCO determines that the Subcontractor has not performed satisfactorily. [42 CFR 438.230(c)(1)(i) - (iii); 42 CFR 438.3(k)]

3.14.2.4 Subcontractors or any other party performing utilization review are required to be licensed in NH.

3.14.3 Notice and Approval

3.14.3.1 The MCO shall submit all Subcontractor agreements and Subcontractor Provider agreements to DHHS, for review at least sixty (60) calendar days prior to the anticipated implementation date of that Subcontractor agreement, any time there is a renewal or extension amendment to a Subcontractor agreement already reviewed by DHHS or there is a substantial change in scope or terms of the Subcontractor agreement.

3.14.3.2 The MCO remains responsible for ensuring that all Agreement requirements are met, including requirements requiring the integration of physical and behavioral health, and that the Subcontractor adheres to all State and federal laws, regulations and related guidance and guidelines.

3.14.3.3 The MCO shall notify DHHS of any change in Subcontractors and shall submit a new Subcontractor agreement for review sixty (60) calendar days prior to the start date of the new Subcontractor agreement.

3.14.3.4 Review by DHHS of a Subcontractor agreement does not relieve the MCO from any obligation or responsibility regarding the

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Subcontractor and does not imply any obligation by DHHS regarding the Subcontractor or Subcontractor agreement.

3.14.3.5 DHHS may grant a written exception to the notice requirements of this Section 3.14.3 (Notice and Approval) if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

3.14.3.6 The MCO shall notify DHHS within five (5) business days of receiving notice from a Subcontractor of its intent to terminate a Subcontractor agreement.

3.14.3.7 The MCO shall notify DHHS of any material breach by Subcontractor of an agreement between the MCO and the Subcontractor that may result in the MCO being non-compliant with or violating this Agreement within one (1) business day of validation that such breach has occurred.

3.14.3.8 The MCO shall take any actions directed by DHHS to cure or remediate said breach by the Subcontractor.

3.14.3.9 In the event of material change, breach or termination of a Subcontractor agreement between the MCO and a Subcontractor, the MCO's notice to DHHS shall include a transition plan for DHHS's review and approval.

3.14.4 MCO Oversight of Subcontractors

3.14.4.1 The MCO shall provide its Subcontractors with training materials regarding preventing fraud, waste and abuse and shall require the MCO's hotline to be publicized to Subcontractors' staff who provide services to the MCO.

3.14.4.2 The MCO shall oversee and be held accountable for any functions and responsibilities that it delegates to any Subcontractor in accordance with 42 CFR 438.230 and 42 CFR Section 438.3, including:

3.14.4.2.1 Prior to any delegation, the MCO shall evaluate the prospective Subcontractor's ability to perform the Social Security activities to be delegated;

3.14.4.2.2 The MCO shall audit the Subcontractor's compliance with its agreement with the MCO and the applicable terms of this Agreement, at least annually and when there is a substantial change in the scope or terms of the Subcontractor agreement; and

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3.14.4.2.3 The MCO shall identify deficiencies or areas for improvement, if any. The MCO shall prompt the Subcontractor to take corrective action.

3.14.4.3 The MCO shall develop and maintain a system for regular and periodic monitoring of each Subcontractor's compliance with the terms of its agreement and this Agreement.

3.14.4.4 If the MCO identifies deficiencies or areas for improvement in the Subcontractor's performance that affect compliance with this Agreement, the MCO shall notify DHHS within seven (7) calendar days and require the Subcontractor to develop a CAP. The MCO shall provide DHHS with a copy of the Subcontractor's CAP within thirty (30) calendar days upon DHHS request, which is subject to DHHS approval [42 CFR 438.230 and 42 CFR Section 438.3]

3.15 Staffing

3.15.1 Key Personnel

3.15.1.1 The MCO shall commit key personnel to the MCM program on a full-time basis. Positions considered to be key personnel, along with any specific requirements for each position, include:

3.15.1.1.1 CEO/Executive Director: Individual shall have clear authority over the general administration and day-to-day business activities of this Agreement.

3.15.1.1.2 Finance Officer: Individual shall be responsible for accounting and finance operations, including all audit activities.

3.15.1.1.3 Medical Director: Individual shall be a physician licensed by the NH Board of Medicine, shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of Covered Services to Members, developing clinical practice standards and clinical policies and procedures.

3.15.1.1.3.1. The Medical Director shall have substantial involvement in QAPI Program activities and shall attend monthly, or as otherwise requested, in-person meetings with the DHHS Medical Director.

3.15.1.1.3.2. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health).

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3.15.1.1.3.3. The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

3.15.1.1.4 Quality Improvement Director: Individual shall be responsible for all QAPI program activities.

3.15.1.1.4.1. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement meetings with DHHS and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.15.1.1.5 Compliance Officer: Individual shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement.

3.15.1.1.5.1. The Compliance Officer shall report directly to the NH-based CEO or the executive director thereof.

3.15.1.1.6 Network Management Director: Individual shall be responsible for development and maintenance of the MCO's Participating Provider network.

3.15.1.1.7 Provider Relations Manager: Individual shall be responsible for provision of all MCO Provider services activities.

3.15.1.1.7.1. The manager shall have prior experience with individual physicians, Provider groups and facilities.

3.15.1.1.8 Member Services Manager: Individual shall be responsible for provision of all MCO Member Services activities.

3.15.1.1.8.1. The manager shall have prior experience with Medicaid populations.

3.15.1.1.9 Utilization Management (UM) Director: Individual shall be responsible for all UM activities.

3.15.1.1.9.1. This person shall be under the direct supervision of the Medical Director and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services.

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3.15.1.1.9.2. The MCO shall also ensure that the UM program assigns responsibility to appropriately licensed clinicians, including a behavioral health and a LTSS professional for those respective services.

3.15.1.1.10 Systems Director/Manager: Individual shall be responsible for all MCO information systems supporting this Agreement, including but not limited to continuity and integrity of operations, continuity flow of records with DHHS's information systems and providing necessary and timely reports to DHHS:

3.15.1.1.11 Encounter Manager: Individual shall be responsible for and qualified by training and experience to oversee encounter submittal and processing to ensure the accuracy, timeliness, and completeness of encounter reporting.

3.15.1.1.12 Claims Manager: Individual shall be responsible for and qualified by training and experience to oversee claims processing and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

3.15.1.1.13 Pharmacy Manager: Individual shall be a pharmacist licensed by the NH Board of Pharmacy and shall have a minimum of five (5) years pharmacy experience as a practicing pharmacist.

3.15.1.1.13.1. The individual shall be responsible for all pharmacy activities, including but not limited to the Lock-In Program, coordinating clinical criteria for Prior Authorizations, compliance with the opioid prescribing requirements outlined in Section 4.11.6 (Substance Use Disorder) and overseeing the Drug Utilization Review (DUR) Board or the Pharmacy and Therapeutics Committee.

3.15.1.1.14 [Amendment #8:] Substance Use Disorder Physician: Effective July 1, 2022, individual shall be an Addiction Medicine Physician licensed by the NH Board of Medicine, and participate under the terms of this Agreement without regard to leeway previously granted by DHHS.

3.15.1.1.14.1. The individual shall be responsible for providing clinical oversight and guidance for the MCO on Substance Use Disorder issues, including issues such as the use of ASAM or other evidence-based assessments and treatment protocols, the use of MAT, engagements with PRSS, and discharge planning for

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Members who visit an ED or are hospitalized for an overdose.

3.15.1.1.14.2. The Substance Use Disorder Physician shall be available to the MCM program on a routine basis for consultations on MCO clinical policy related to Substance Use Disorders and the cases of individual Members, as needed.

3.15.1.2 Coordinators shall be responsible for overseeing Care Coordination and Care Management activities for MCO Members with complex medical, behavioral health, DD, and long term care needs; or for overseeing other activities.

3.15.1.3 Coordinators shall also serve as liaisons to DHHS staff for their respective functional areas. The MCO shall assign coordinators to each of the following areas on a full-time basis:

3.15.1.3.1 Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.15.1.3.1.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

3.15.1.3.1.2. The Special Needs Coordinator shall be responsible for ensuring compliance with and implementation of requirements for Adults and Children with Special Care Needs related to Care Management, Network Adequacy, access to Benefits, and Utilization Management.

3.15.1.3.1.3. [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ ~~2024~~, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions.

3.15.1.3.2 Developmental Disability Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

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3.15.1.3.2.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

3.15.1.3.2.2. The Developmental Disability Coordinator shall be responsible for ensuring coordination with LTSS Case Managers for Members enrolled in the MCO but who have services covered outside of the MCO's Covered Services.

3.15.1.3.2.3. [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ ~~2024~~, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions.

3.15.1.3.3 Mental Health Coordinator: Individual shall oversee the delivery of Mental Health Services to ensure that there is a single point of oversight and accountability.

3.15.1.3.3.1. Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.15.1.3.3.2. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within Community Mental Health Services.

3.15.1.3.3.3. Other key functions shall include coordinating Mental Health Services across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; implementation and interpretation of clinical

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policies and procedures; and Social Determinants of Health and community-based resources.

3.15.1.3.4 Substance Use Disorder Coordinator: Individual shall be an addiction medicine specialist on staff or under contract who works with the Substance Use Disorder Physician to provide clinical oversight and guidance to the MCO on Substance Use Disorder issues.

3.15.1.3.4.1. The Substance Use Disorder Coordinator shall be a Masters Licensed Alcohol and Drug Counselor (MLADC) or Licensed Mental Health Professional who is able to demonstrate experience in the treatment of Substance Use Disorder.

3.15.1.3.4.2. The individual shall have expertise in screening, assessments, treatment, and Recovery strategies; use of MAT; strategies for working with child welfare agencies, correctional institutions and other health and social service agencies that serve individuals with Substance Use Disorders.

3.15.1.3.4.3. The individual shall be available to the MCM program on a routine basis for consultations on clinical, policy and operational issues, as well as the disposition of individual cases.

3.15.1.3.4.4. Other key functions shall include coordinating Substance Use Disorder services and treatment across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; and social determinants of health and community-based resources.

3.15.1.3.5 Long Term Care Coordinator: Individual shall be responsible for coordinating managed care Covered Services with FFS and waiver programs.

3.15.1.3.5.1. The individual shall have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management

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responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care services.

3.15.1.3.5.2. [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024~~June 30, 2023~~~~June 30~~~~December 31, 2022~~~~2024~~, the Long Term Care Coordinator position is not required.

3.15.1.3.6 Grievance Coordinator: Individual shall be responsible for overseeing the MCO's Grievance System.

3.15.1.3.7 Fraud, Waste, and Abuse Coordinator: Individual shall be responsible for tracking, reviewing, monitoring, and reducing fraud, waste and abuse.

3.15.1.3.8 [Amendment #5:] Housing Coordinator: Except as described at Sections 3.15.1.3.8.7, 3.15.2.4.5, and 4.11.5.7.2.1, the individual shall be responsible for helping to identify, secure, and maintain community based housing for Members and developing, articulating, and implementing a broader housing strategy within the MCO to expand housing availability/options.

3.15.1.3.8.1. The Housing Coordinator shall act as the MCO's central housing expert/resource, providing education and assistance to all MCO's relevant staff (care managers and others) regarding supportive housing services and related issues.

3.15.1.3.8.2. The Housing Coordinator shall be a dedicated staff person whose primary responsibility is housing-related work.

3.15.1.3.8.3. The Housing Coordinator shall not be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO.

3.15.1.3.8.4. The Housing Coordinator shall act as a liaison with the Department's Bureau of Housing and Homeless Services to receive training and work in collaboration on capacity requirements/building.

3.15.1.3.8.5. The Housing Coordinator shall have at least two (2) year's full-time experience is assisting vulnerable populations to secure accessible, affordable housing.

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3.15.1.3.8.6. The Coordinator shall be familiar with the relevant public and private housing resources and stakeholders.

3.15.1.3.8.7. Amendment #10: [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ 2024, the Housing Coordinator position is not required.

3.15.1.3.9 Prior Authorization Coordinator: Individual shall be responsible for all MCO Utilization Management activities and shall work under the direct supervision of the Medical Director.

3.15.1.3.9.1. The Prior Authorization Coordinator shall ensure that all staff performing prior authorization functions have the necessary clinical backgrounds needed to apply established coverage criteria and make appropriate decisions based on medical necessary.

3.15.1.3.9.2. The individual shall be licensed by the NH Board of Nursing and have a minimum of eight (8) years of demonstrated experience in both the provision of direct clinical services as well as progressively increasing levels of management responsibilities with a particular focus on performance of a variety of utilization functions including conducting inter-rater reliability quality audits.

3.15.2 Other MCO Required Staff

3.15.2.1 Fraud, Waste, and Abuse Staff: The MCO shall establish a Special Investigations Unit (SIU), which shall be comprised of experienced fraud, waste and abuse investigators who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein.

3.15.2.1.1 At a minimum, the SIU shall have at least two (2) fraud, waste and abuse investigators and one (1) Fraud, Waste and Abuse Coordinator.

3.15.2.1.2 The MCO shall adequately staff the SIU to ensure that the MCO meets Agreement provisions of Section 5.3.2 (Fraud, Waste and Abuse).

3.15.2.2 Behavioral Health Clinical Providers to Minimize Psychiatric Boarding: The MCO shall supply a sufficient number of

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hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to, or at risk for, Psychiatric Boarding.

3.15.2.2.1 The number of such hospital-credentialed Providers shall be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed.

3.15.2.2.2 The initial on-site assistance provided within these required timelines shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or another Designated Receiving Facility.

3.15.2.2.3 Each such hospital-credentialed Provider shall have the clinical expertise to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources, that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required.

3.15.2.2.3.1. [Amendment #10:] ~~[Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:]~~ For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023 June 30, December 31, 2022 2024~~, the Psychiatric Boarding program's hospital-credentialed Provider position(s) are not required.

3.15.2.3 ~~[Amendment #8:]~~ Staff for Members at New Hampshire Hospital: The MCO shall designate an off-site ~~on-site~~ liaison with privileges at New Hampshire Hospital to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to New Hampshire Hospital.

3.15.2.3.1 [Amendment #10:] ~~[Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:]~~ For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023 June 30 December 31, 2022 2024~~, the Staff for Members at New Hampshire Hospital position is not required.

3.15.2.4 [Amendment #5:] Additional Behavioral Health Staff: Except as described at Sections 3.15.1.3.8.7, 3.15.2.4.5, and 4.11.5.7.2.1, the MCO shall designate one (1) or more staff who have behavioral health specific managed care experience to provide in-person housing assistance to Members who are homeless and oversee:

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- 3.15.2.4.1 Behavioral health Care Management;
- 3.15.2.4.2 Behavioral health Utilization Management;
- 3.15.2.4.3 Behavioral health network development; and
- 3.15.2.4.4 The behavioral health Subcontract, as applicable.
- 3.15.2.4.5 [Amendment #10:] ~~[Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:]~~ For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023 June 30 December 31, 2022 2024~~, the Behavioral Health Staff position responsible for in-person housing assistance is not required.
- 3.15.2.5 Any subcontracted personnel or entity engaged in decision-making for the MCO regarding clinical policies related to Substance Use Disorder or mental health shall have demonstrated experience working in direct care for Members with Substance Use Disorder or mental health.
- 3.15.2.6 [Amendment #5:] ~~The crisis lines and~~ Emergency Services teams shall employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention calls and who have access to a clinician available to evaluate the Member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

3.15.3 On-Site Presence

- 3.15.3.1 The MCO shall have an on-site presence in New Hampshire. On-site presence for the purposes of this Section 3.15.3 of the Agreement means that the MCO's personnel identified below regularly reports to work in the State of New Hampshire:
 - 3.15.3.1.1 CEO/Executive Director;
 - 3.15.3.1.2 Medical Director;
 - 3.15.3.1.3 [Amendment #5:] Intentionally Left Blank ~~Quality Improvement Director;~~
 - 3.15.3.1.4 [Amendment #5:] Intentionally Left Blank ~~Compliance Officer;~~
 - 3.15.3.1.5 Network Management Director;
 - 3.15.3.1.6 Provider Relations Manager;
 - 3.15.3.1.7 [Amendment #5:] Intentionally Left Blank ~~Utilization Management Director;~~
 - 3.15.3.1.8 Pharmacy Manager;

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- 3.15.3.1.9 Substance Use Disorder Physician;
- 3.15.3.1.10 Special Needs Coordinator;
- 3.15.3.1.11 Mental Health Coordinator;
- 3.15.3.1.12 Substance Use Disorder Coordinator;
- 3.15.3.1.13 DD Coordinator;
- 3.15.3.1.14 Long Term Care Coordinator;
- 3.15.3.1.15 Housing Coordinator;
- 3.15.3.1.16 Grievance Coordinator;
- 3.15.3.1.17 Fraud, Waste, and Abuse Coordinator; and
- 3.15.3.1.18 [Amendment #5:] Intentionally Left Blank Prior Authorization Coordinator.

3.15.3.2 Upon DHHS's request, MCO required staff who are not located in New Hampshire shall travel to New Hampshire for in-person meetings.

3.15.3.3 The MCO shall provide to DHHS for review and approval key personnel and qualifications no later than sixty (60) calendar days prior to the start of the program.

3.15.3.4 The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by DHHS; which approval shall not be unreasonably withheld.

3.15.3.5 [Amendment #5:] DHHS may grant a written exception to the notice requirements of this section if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

3.15.4 General Staffing Provisions

3.15.4.1 The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely manner as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS may impose liquidated damages, in accordance with Section 5.5.2 (Liquidated Damages).

3.15.4.2 The MCO shall ensure that all staff receive appropriate training, education, experience, and orientation to fulfill the

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requirements of the positions they hold and shall verify and document that it has met this requirement.

3.15.4.2.1 This includes keeping up-to-date records and documentation of all individuals requiring licenses and/or certifications and such records shall be available for DHHS inspection.

3.15.4.3 All key personnel shall be generally available during DHHS hours of operation and available for in-person or video conferencing meetings as requested by DHHS.

3.15.4.3.1 The MCO key personnel, and others as required by DHHS, shall, at a minimum, be available for monthly in-person meetings in NH with DHHS.

3.15.4.4 The MCO shall make best efforts to notify DHHS at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel.

3.15.4.5 If a member of the MCO's key personnel is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform DHHS within seven (7) calendar days, and submit a transition plan with proposed alternate staff to DHHS for review and approval, for which approval shall not be unreasonably withheld.

3.15.4.5.1 The Staffing Transition Plan shall include, but is not limited to:

3.15.4.5.1.1. The allocation of resources to the Agreement during key personnel vacancy;

3.15.4.5.1.2. The timeframe for obtaining key personnel replacements within ninety (90) calendar days; and

3.15.4.5.1.3. The method for onboarding staff and bringing key personnel replacements/additions up-to-date regarding this Agreement.

4 PROGRAM REQUIREMENTS

4.1 Covered Populations and Services

4.1.1 Overview of Covered Populations

4.1.1.1 The MCO shall provide and be responsible for the cost of managed care services to population groups deemed by DHHS to be eligible for managed care and to be covered under the terms of this Agreement, as indicated in the table below.

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4.1.1.2 Members enrolled with the MCO who subsequently become ineligible for managed care during MCO enrollment shall be excluded from MCO participation. DHHS shall, based on State or federal statute, regulation, or policy, exclude other Members as appropriate.

Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Aid to the Needy Blind Non-Dual	X	
Aid to the Permanently and Totally Disabled Non-Dual	X	
American Indians and Alaskan Natives	X	
Auto Eligible and Assigned Newborns	X	
Breast and Cervical Cancer Program	X	
Children Enrolled in Special Medical Services/Partners in Health	X	
Children with Supplemental Security Income	X	
Family Planning Only Benefit		X
Foster Care/Adoption Subsidy	X	
Granite Advantage (Medicaid Expansion Adults, Frail/Non-Frail)	X	
Health Insurance Premium Payment		X
Home Care for Children with Severe Disabilities (Katie Beckett)	X	
In and Out Spend-Down		X
Medicaid Children Funded through the Children's Health Insurance Program	X	

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Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Medicaid for Employed Adults with Disabilities Non-Dual	X	
<u>[Amendment #5:] Medicaid for Employed Older Adults with Disabilities</u>	X	
Medicare Duals with full Medicaid Benefits	X	
Medicare Savings Program Only (no Medicaid services)		X
Members with Veterans Affairs Benefits		X
Non-Expansion Poverty Level Adults (Including Pregnant Women) and Children Non-Dual	X	
Old Age Assistance Non-Dual	X	
Retroactive/Presumptive Eligibility Segments (excluding Auto Eligible Newborns)		X
Third Party Coverage Non-Medicare, Except Members with Veterans Affairs Benefits	X	

4.1.2 Overview of Covered Services

4.1.2.1 The MCO shall cover the physical health, behavioral health, pharmacy, and other benefits for all MCO Members, as indicated in the summary table below and described in this Agreement. Additional requirements for Behavioral Health Services are included in Section 4.11 (Behavioral Health), and additional requirements for pharmacy are included in Section 4.2 (Pharmacy Management).

4.1.2.2 The MCO shall provide, at a minimum, all services identified in the following matrix, and all services in accordance with the CMS-approved Medicaid State Plan and Alternative Benefit Plan State Plan. The MCO shall cover services consistent with 45 CFR 92.207(b).

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4.1.2.3 While the MCO may provide a higher level of service and cover more services than required by DHHS (as described in Section 4.1.3 (Covered Services Additional Provisions), the MCO shall, at a minimum, cover the services identified at least up to the limits described in NH Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. DHHS reserves the right to alter this list at any time by providing reasonable notice to the MCO. [42 CFR 438.210(a)(1) and (2)]

4.1.2.3.1 [Amendment #6:] Covered home visiting services shall be consistent with State regulatory rules in effect.

Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Acquired Brain Disorder Waiver Services		X
Adult Medical Day Care	X	
Advanced Practice Registered Nurse	X	
Ambulance Service	X	
Ambulatory Surgical Center	X	
Audiology Services	X	
[Amendment #7] Intentionally Left Blank -Behavioral Health Crisis Treatment Center⁸	X	
Certified Non-Nurse Midwife	X	
Choices for Independence Waiver Services		X
Child Health Support Service – Division for Children, Youth & Families, except for services eligible under EPSDT		X

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Community Mental Health Services ⁹	X	
Crisis Intervention – Division for Children, Youth & Families		X
Developmental Disability Waiver Services		X
Dental Benefit Services ¹⁰		X
Designated Receiving Facilities	X	
Developmental Services Early Supports and Services		X
Early and Periodic Screening, Diagnostic and Treatment Services including Applied Behavioral Analysis Coverage	X	
Family Planning Services	X	
Freestanding Birth Centers	X	
Furnished Medical Supplies & Durable Medical Equipment	X	
Glenclyff Home		X
Home Based Therapy – Division for Children, Youth & Families		X
Home Health Services	X	
Home Visiting Services	X	

⁹ [Amendment #10] [Amendment #9] [Amendment #8:] [Amendment #7:] For the period July 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30, December 31, 2022~~, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

¹⁰ [Amendment #10:] Effective April 1, 2023, certain preventive, restorative, denture and other oral health services are carved-out of the MCM Program and covered under the State's contract with Delta Dental of New Hampshire, Inc. for eligible adults ages 21 years and over. Dental and oral health emergency services for Medicaid enrolled children and adults of all ages will continue to be Covered Services under the MCM Program.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered).
Hospice	X	
Home and Community-Based In Home Support Services		X
Inpatient Hospital	X	
Inpatient Hospital Swing Beds, Intermediate Care Facility		X
Inpatient Hospital Swing Beds, Skilled Nursing Facility		X
Inpatient Psychiatric Facility Services Under Age Twenty-One (21) ¹¹	X	
[Amendment #9:] [Amendment #8:] Inpatient Psychiatric Treatment in State-owned New Hampshire Hospital and Hampstead Hospital, and Other State Determined IMD for Mental Illness Inpatient Psychiatric Treatment in an Institution for Mental Disease, excluding New Hampshire Hospital¹²	X	
Intensive Home and Community-Based Services– Division for Children, Youth & Families		X
Intermediate Care Facility Atypical Care		X
Intermediate Care Facility for Members with Intellectual Disabilities ¹³		X
Intermediate Care Facility Nursing Home		X
Laboratory (Pathology)	X	
Medicaid to Schools Services		X
Medical Services Clinic (e.g. Opioid Treatment Program)	X	

¹¹ Under age 22 if individual admitted prior to age 21

¹² ~~[Amendment #9:] [Amendment #8:] Beginning July 1, 2022, Medicaid managed care inpatient psychiatric treatment at State-owned New Hampshire Hospital and Hampstead Hospital, and other State determined IMD for mental illness is covered up to sixty (60) days for adults age 21-64 due to a primary diagnosis of mental illness. Pursuant to 42 CFR 438.6 and 42 CFR 438.3(e)(2)(i) through (iii)~~

¹³ E.g., Cedarcrest

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Non-Emergency Medical Transportation ¹⁴	X	
Occupational Therapy ¹⁵	X	
Optometric Services Eyeglasses	X	
Outpatient Hospital ¹⁶	X	
<u>[Amendment #8:] Pediatric Residential Treatment Facility Services (effective September 1, 2019)</u>		X
Personal Care Services	X	
Physical Therapy ¹⁷	X	
Physicians Services	X	
Placement Services – Division for Children, Youth & Families		X
Podiatrist Services	X	
Prescribed Drugs	X	
Private Duty Nursing	X	
Private Non-Medical Institutional For Children – Division for Children, Youth & Families		X
Psychology	X	
<u>[Amendment #8:] Qualified Residential Treatment Program Services (effective September 1, 2019)</u>		X
Rehabilitative Services Post Hospital Discharge	X	

¹⁴ Also includes mileage reimbursement for Medically Necessary travel

¹⁵ Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services

¹⁶ Including facility and ancillary services for dental procedures

¹⁷ Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Rural Health Clinic & Federally Qualified Health Centers	X	
Non-Swing Bed Skilled Nursing Facilities		X
Skilled Nursing Facilities Skilled Nursing Facilities Atypical Care		X
Speech Therapy ¹⁸	X	
Substance Use Disorder Services (Per He-W 513) – including services provided in Institutions for Mental Diseases pursuant to an approved 1115(a) research and demonstration waiver	X	
Transitional Housing Program Services and Community Residential Services With Wrap-Around Services and Supports ¹⁹	X	
Wheelchair Van	X	
X-Ray Services	X	

4.1.3 Covered Services Additional Provisions

4.1.3.1 Nothing in this Section 4.1.3 shall be construed to limit the MCO's ability to otherwise voluntarily provide any other services in addition to the services required to be provided under this Agreement.

4.1.3.2 The MCO shall seek written approval from DHHS, bear the entire cost of the service, and the utilization and cost of such voluntary services shall not be included in determining payment rates.

4.1.3.3 All services shall be provided in accordance with 42 CFR 438.210 and 42 CFR 438.207(b). The MCO shall ensure there is no disruption in service delivery to Members or Providers as the MCO transitions these services into Medicaid managed care from FFS.

¹⁸ Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services

¹⁹ [Amendment #6:] Beginning no earlier than Amendment #7 [Amendment #4:] Beginning on July 1, 2021 [Amendment #2:] July 1, 2020. [Base Contract:] Beginning on January 1, 2020.

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4.1.3.4 The MCO shall adopt written policies and procedures to verify that services are actually provided. [42 CFR 455.1(a)(2)]

4.1.3.5 In Lieu Of Services

4.1.3.5.1 [Amendment #10:] The MCO may provide Members with services or settings that are "In Lieu Of" Services or settings with prior approval and in accordance with federal regulations included in the Medicaid State Plan that are more medically appropriate, cost-effective substitutes for the Medicaid State Plan services. The MCO may cover In Lieu Of Services if:

4.1.3.5.1.1. Intentionally left blank DHHS determines that the alternative service or setting is a medically appropriate and cost-effective substitute;

4.1.3.5.1.2. Intentionally left blank The Member is not required to use the alternative service or setting;

4.1.3.5.1.3. Intentionally left blank The In Lieu Of Service has been authorized by DHHS; and

4.1.3.5.1.4. Intentionally left blank The in Lieu Of Service has been offered to Members at the option of the MCO. [42 CFR 438.3(e)(2)(i) - (iii)]

4.1.3.5.1.5. [Amendment #10:] Any In Lieu of Services on record prior to January 3, 2023 and proposed for continuation must comply with CMS federal regulations beginning January 1, 2024. [42 CFR 438.3(e)(2)(i) - (iii); SMDL 1/4/23]

4.1.3.5.2 [Amendment #10:] Intentionally left blank DHHS may determine that the alternative service or setting is a medically appropriate and cost-effective substitute by either: prospectively providing to the MCO a list of services that the MCO may consider In Lieu Of Services; or by the MCO receiving approval from DHHS to implement an In Lieu Of Service.

4.1.3.5.3 [Amendment #10:] Beginning September 1, 2019, DHHS has authorized medical nutrition, diabetes self-management, and assistance in finding and keeping housing (not including rent), as In Lieu Of Services. This list may be expanded upon or otherwise modified by DHHS through amendments of this Agreement. Previously authorized In Lieu Of Services are scheduled for review and modification as may be necessary to meet federal regulatory compliance effective January 1, 2024.

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4.1.3.5.4 [Amendment #10:] Intentionally left blank ~~For the MCO to obtain approval for In-Lieu Of Services not authorized by DHHS, the MCO shall submit an In-Lieu Of Service request to DHHS for each proposed In-Lieu of Service not yet authorized.~~

4.1.3.5.5 [Amendment #10:] ~~The MCO shall support In-Lieu of Services reporting~~ monitor the cost-effectiveness of each approved In-Lieu of Service by tracking utilization and expenditures and submit an annual update providing an evaluation of the cost-effectiveness of the alternative service during the previous twelve (12) months, in accordance with federal regulations and Exhibit O.

4.1.3.6 [Amendment #8:] Intentionally Left Blank ~~Institution for Mental Diseases (IMD)~~

4.1.3.6.1 [Amendment #8:] Intentionally left blank. Pursuant to 42 CFR 438.6, ~~the MCO shall pay for up to fifteen (15) inpatient days per calendar month for any Member who is receiving treatment in an IMD that is not a state owned or operated facility for the primary treatment of a psychiatric disorder.~~

4.1.3.6.2 [Amendment #8:] Intentionally left blank. ~~The MCO shall not pay for any days in a given month if the Member exceeds fifteen (15) inpatient days for that month in an IMD that is not a state owned or operated facility, unless otherwise indicated by DHHS and permitted as a result of a federal waiver or other authority. The provision of inpatient psychiatric treatment in an IMD shall meet the requirements for In-Lieu of Services at 42 CFR 438.3(e)(2)(i) (iii).~~

4.1.3.7 Telemedicine

4.1.3.7.1 The MCO shall comply with provisions of RSA 167:4(d) by providing access to telemedicine services to Members in certain circumstances.

4.1.3.7.2 The MCO shall develop a telemedicine clinical coverage policy and submit the policy to DHHS for review. Covered telemedicine modalities shall comply with all local, State and federal laws including the HIPAA and record retention requirements.

4.1.3.7.3 The clinical policy shall demonstrate how each covered telemedicine modality ensures security of PHI, including data security and encryption policies.

4.1.3.8 Non-Participating Indian Health Care Providers

4.1.3.8.1 American Indian/Alaska Native Members are permitted to obtain Covered Services from Non-Participating Indian Health

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Care Providers (IHCP) from whom the Member is otherwise eligible to receive such services. [42 CFR 438.14(b)(4)]

4.1.3.8.2 The MCO shall permit any American Indian/Alaska Native Member who is eligible to receive services from an IHCP PCP that is a Participating Provider, to choose that IHCP as their PCP, as long as that Provider has capacity to provide the services. [American Reinvestment and Recovery Act 5006(d); SMDL 10-001; 42 CFR 438.14(b)(3)]

4.1.3.9 Moral and Religious Grounds

4.1.3.9.1 An MCO that would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(a)(2)]

4.1.3.9.2 If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the MCO shall furnish information about the services it does not cover to DHHS with its application for a Medicaid contract and any time thereafter when it adopts such a policy during the Term of this Agreement. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(b)(1)(i)(A)(1)-(2)]

4.1.3.9.3 If the MCO does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information on how and where to obtain such services, DHHS shall provide that information to potential Members upon request. [42 CFR 438.10(e)(2)(v)(C)]

4.1.4 Cost Sharing

4.1.4.1 Any cost sharing imposed on Medicaid Members shall be in accordance with NH's Medicaid Cost Sharing State Plan Amendment and Medicaid FFS requirements pursuant to 42 CFR 447.50 through 42 CFR 447.82. [Sections 1916(a)(2)(D) and 1916(b)(2)(D) of the Social Security Act; 42 CFR 438.108; 42 CFR 447.50 - 82; SMDL 6/16/06]

4.1.4.2 With the exception of Members who are exempt from cost sharing as described in the Medicaid Cost Sharing State Plan Amendment, the MCO shall require point of service (POS) Copayment for services for Members deemed by DHHS to have annual incomes at or above one hundred percent (100%) of the FPL as follows:

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4.1.4.2.1 A Copayment of one dollar (\$1.00) shall be required for each preferred prescription drug and each refill of a preferred prescription drug;

4.1.4.2.2 A Copayment of two dollars (\$2.00) shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug, unless the prescribing Provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the Copay for the non-preferred drug shall be one dollar (\$1.00);

4.1.4.2.3 A Copayment of one dollar (\$1.00) shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug; and

4.1.4.3 The following services are exempt from co-payments:

4.1.4.3.1 emergency services,

4.1.4.3.2 family planning services,

4.1.4.3.3 preventive services provided to children,

4.1.4.3.4 pregnancy-related services,

4.1.4.3.5 services resulting from potentially preventable events, and,

4.1.4.3.6 Cloriril (Clozapine) prescriptions. [42 CFR 447.56(a)]

4.1.4.4 Members are exempt from Copayments when:

4.1.4.4.1 The Member falls under the designated income threshold (one hundred percent (100%) or below the FPL);

4.1.4.4.2 The Member is under eighteen (18) years of age;

4.1.4.4.3 The Member is in a nursing facility or in an ICF for Members with IDs;

4.1.4.4.4 The Member participates in one (1) of the HCBS waiver programs;

4.1.4.4.5 The Member is pregnant and receiving services related to their pregnancy or any other medical condition that might complicate the pregnancy;

4.1.4.4.6 The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within sixty (60) calendar days after the month the pregnancy ended;

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4.1.4.4.7 The Member is in the Breast and Cervical Cancer Treatment Program;

4.1.4.4.8 The Member is receiving hospice care; or

4.1.4.4.9 The Member is an American Indian/Alaska Native.

4.1.4.5 Any American Indian/Alaskan Native who has ever received or is currently receiving an item or service furnished by an IHCP or through referral under contract health services shall be exempt from all cost sharing including Copayments and Premiums. [42 CFR 447.52(h); 42 CFR 447.56(a)(1)(x); ARRA 5006(a); 42 CFR 447.51(a)(2); SMDL 10-001]

4.1.5 Emergency Services

4.1.5.1 The MCO shall cover and pay for Emergency Services at rates that are no less than the equivalent DHHS FFS rates if the Provider that furnishes the services has an agreement with the MCO. [Section 1852(d)(2) of the Social Security Act; 42 CFR 438.114(b); 42 CFR 422.113(c)]

4.1.5.2 If the Provider that furnishes the Emergency Services does not have an agreement with the MCO, the MCO shall cover and pay for the Emergency Services in compliance with Section 1932(b)(2)(D) of the Social Security Act, 42 CFR 438.114(c)(1)(i), and the SMDL 3/20/98.

4.1.5.3 The MCO shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Participating Provider.

4.1.5.4 The MCO shall pay Non-Participating Providers of Emergency and Post-Stabilization Services an amount no more than the amount that would have been paid under the DHHS FFS system in place at the time the service was provided. [SMDL 3/31/06; Section 1932(b)(2)(D) of the Social Security Act]

4.1.5.5 The MCO shall not deny treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of Emergency Medical Condition.

4.1.5.6 The MCO shall not deny payment for treatment obtained when a representative, such as a Participating Provider, or the MCO instructs the Member to seek Emergency Services [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A) - (B)].

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4.1.5.7 The MCO shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

4.1.5.8 The MCO shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP, MCO, or DHHS of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. [42 CFR 438.114(d)(1)(i) - (ii)]

4.1.5.9 The MCO may not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. [42 CFR 438.114(d)(2)]

4.1.5.10 The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment. [42 CFR 438.114(d)(3)]

4.1.6 Post-Stabilization Services

4.1.6.1 Post-Stabilization Services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for Post-Stabilization Services:

4.1.6.1.1 Obtained within or outside the MCO that are pre-approved by a Participating Provider or other MCO representative;

4.1.6.1.2 Obtained within or outside the MCO that are not pre-approved by a Participating Provider or other MCO representative, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services; and/or

4.1.6.1.3 Administered to maintain, improve or resolve the Member's stabilized condition without pre-authorization, and regardless of whether the Member obtains the services within the MCO network if:

4.1.6.1.3.1. The MCO does not respond to a request for pre-approval within one (1) hour;

4.1.6.1.3.2. The MCO cannot be contacted; or

4.1.6.1.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the Member's care and an MCO physician is

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not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with an MCO physician, and the treating physician may continue with care of the patient until an MCO physician is reached or one (1) of the criteria of 42 CFR 422.133(c)(3) is met. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)-(ii); 422.113(c)(2)(iii)(A)-(C)]

4.1.6.2 The MCO shall limit charges to Members for Post-Stabilization Services to an amount no greater than what the organization would charge the Member if the Member had obtained the services through the MCO. [[42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)]

4.1.6.3 The MCO's financial responsibility for Post-Stabilization Services, if not pre-approved, ends when:

4.1.6.3.1 The MCO physician with privileges at the treating hospital assumes responsibility for the Member's care;

4.1.6.3.2 The MCO physician assumes responsibility for the Member's care through transfer;

4.1.6.3.3 The MCO representative and the treating physician reach an agreement concerning the Member's care; or

4.1.6.3.4 The Member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i) - (iv)]

4.1.7 Value-Added Services

4.1.7.1 The MCO may elect to offer Value-Added Services that are not covered in the Medicaid State Plan or under this Agreement in order to improve health outcomes, the quality of care, or reduce costs, in compliance with 42 CFR 438.3(e)(i).

4.1.7.2 Value-Added Services are services that are not currently provided under the Medicaid State Plan. The MCO may elect to add Value-Added Services not specified in the Agreement at the MCO's discretion, but the cost of these Value-Added Services shall not be included in Capitation Payment calculations. The MCO shall submit to DHHS an annual list of the Value-Added Services being provided.

4.1.8 Early and Periodic Screening, Diagnostic, and Treatment

4.1.8.1 The MCO shall provide the full range of preventive, screening, diagnostic and treatment services including all medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions for EPSDT eligible beneficiaries ages

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birth to twenty-one in accordance with 1905(r) of the Social Security Act. [42 CFR 438.210(a)(5)]

4.1.8.2 The MCO shall determine whether a service is Medically Necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. Section 1396d(r), 42 CFR 438.210, and 42 CFR Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21, and the particular needs of the child and consistent with the definition for Medical Necessity included in this Agreement.

4.1.8.3 Upon conclusion of an individualized review of medical necessity, the MCO shall cover all Medically Necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. Section 1396d(a), regardless of whether such services are covered under the Medicaid State Plan and regardless of whether the request is labeled as such, with the exception of all services excluded from the MCO.

4.1.8.4 The MCO may provide Medically Necessary services in the most economic mode possible, as long as:

4.1.8.4.1 The treatment made available is similarly efficacious to the service requested by the Member's physician, therapist, or other licensed practitioner;

4.1.8.4.2 The determination process does not delay the delivery of the needed service; and

4.1.8.4.3 The determination does not limit the Member's right to a free choice of Participating Providers within the MCO's network.

4.1.8.5 Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services same day, or location of service) in the MCO clinical coverage policies, service definitions, or billing codes do not apply to Medicaid Members less than twenty-one (21) years of age, when those services are determined to be Medically Necessary per federal EPSDT criteria.

4.1.8.6 If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved per EPSDT criteria as Medically Necessary to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.

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4.1.8.7 The MCO shall not require Prior Authorization for Non-Symptomatic Office Visits (early and periodic screens/wellness visits) for Members less than twenty-one (21) years of age. The MCO may require Prior Authorization for other diagnostic and treatment products and services provided under EPSDT.

4.1.8.8 The MCO shall conduct Prior Authorization reviews using current clinical documentation, and shall consider the individual clinical condition and health needs of the child Member. The MCO shall not make an adverse benefit determination on a service authorization request for a Member less than twenty-one (21) years of age until the request is reviewed per EPSDT criteria.

4.1.8.9 While an EPSDT request is under review, the MCO may suggest alternative services that may be better suited to meet the Member's needs, engage in clinical or educational discussions with Members or Providers, or engage in informal attempts to resolve Member concerns as long as the MCO makes clear that the Member has the right to request authorization of the services he or she wants to request.

4.1.8.10 The MCO shall develop effective methods to ensure that Members less than twenty-one (21) years of age receive all elements of preventive health screenings recommended by the AAP in the Academy's most currently published Bright Futures preventive pediatric health care periodicity schedule using a validated screening tool. The MCO shall be responsible for requiring in contracts that all Participating Providers that are PCPs perform such screenings.

4.1.8.11 The MCO shall require that PCPs that are Participating Providers include all the following components in each medical screening:

4.1.8.11.1 Comprehensive health and developmental history that assesses for both physical and mental health, as well as for Substance Use Disorders;

4.1.8.11.2 Screening for developmental delay at each visit through the fifth (5th) year using a validated screening tool;

4.1.8.11.3 Screening for Autism Spectrum Disorders per AAP guidelines;

4.1.8.11.4 Comprehensive, unclothed physical examination;

4.1.8.11.5 All appropriate immunizations, in accordance with the schedule for pediatric vaccines, laboratory testing (including blood lead screening appropriate for age and risk factors); and

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4.1.8.11.6 Health education and anticipatory guidance for both the child and caregiver.

4.1.8.12 The MCO shall include the following information related to EPSDT in the Member Handbook:

4.1.8.12.1 The benefits of preventive health care;

4.1.8.12.2 Services available under the EPSDT program and where and how to obtain those services;

4.1.8.12.3 That EPSDT services are not subject to cost-sharing; and

4.1.8.12.4 That the MCO shall provide scheduling and transportation assistance for EPSDT services upon request by the Member.

4.1.8.13 The MCO shall perform outreach to Members who are due or overdue for an EPSDT screening service on a monthly basis.

4.1.8.13.1 The MCO shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed as a result of conditions disclosed during screenings and diagnosis.

4.1.8.14 The MCO shall submit its EPSDT plan for DHHS review and approval as part of its Readiness Review and in accordance with Exhibit O.

4.1.9 Non-Emergency Medical Transportation (NEMT)

4.1.9.1 The MCO shall arrange for the NEMT of its Members to ensure Members receive Medically Necessary care and services covered by the Medicaid State Plan regardless of whether those Medically Necessary Services are covered by the MCO.

4.1.9.1.1 [Amendment #10:] [Amendment #7:] For the federal COVID-19 Public Health Emergency period beginning March 18, 2020, The MCO shall assume medical necessity for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility.

4.1.9.2 The MCO shall provide the most cost-effective and least expensive mode of transportation to its Members. However, the MCO shall ensure that a Member's lack of personal transportation is not a barrier of accessing care. The MCO and/or any Subcontractors shall be required to comply with all of the NEMT Medicaid State Plan requirements.

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4.1.9.3 The MCO shall ensure that its Members utilize a Family and Friends Mileage Reimbursement Program if they have a car, or a friend or family member with a car, who can drive them to their Medically Necessary service. A Member with a car who does not want to enroll in the Family and Friends Program shall meet one (1) of the following criteria to qualify for transportation services:

4.1.9.3.1 Does not have a valid driver's license;

4.1.9.3.2 Does not have a working vehicle available in the household;

4.1.9.3.3 Is unable to travel or wait for services alone; or

4.1.9.3.4 Has a physical, cognitive, mental or developmental limitation.

4.1.9.4 The MCO shall make good faith effort to achieve a fifty percent (50%) rate of total NEMT one-way rides provided by the MCO through the Family and Friends Mileage Reimbursement Program.

4.1.9.4.1 [Amendment #9:] Effective January 1, 2023, plus an additional ninety (90) day ramp up period to allow for related Member and vendor communications, the Family and Friends mileage reimbursement rate will increase to 62.5 cents per mile. The rate is based on the Internal Revenue Service (IRS) defined standard mileage rate effective on July 1, 2022.

4.1.9.5 If no car is owned or available, the Member shall use public transportation if:

4.1.9.5.1 The Member lives less than one half mile from a bus route;

4.1.9.5.2 The Provider is less than one half mile from the bus route; and

4.1.9.5.3 The Member is an adult under the age of sixty-five (65).

4.1.9.6 Exceptions the above public transportation requirement are:

4.1.9.6.1 The Member has two (2) or more children under age six (6) who shall travel with the parent;

4.1.9.6.2 The Member has one (1) or more children over age six (6) who has limited mobility and shall accompany the parent to the appointment; or

4.1.9.6.3 The Member has at least one (1) of the following conditions:

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- 4.1.9.6.3.1. Pregnant or up to six (6) weeks post-partum,
- 4.1.9.6.3.2. Moderate to severe respiratory condition with or without an oxygen dependency,
- 4.1.9.6.3.3. Limited mobility (walker, cane, wheelchair, amputee, etc.),
- 4.1.9.6.3.4. Visually impaired,
- 4.1.9.6.3.5. Developmentally delayed,
- 4.1.9.6.3.6. Significant and incapacitating degree of mental illness, or
- 4.1.9.6.3.7. Other exception by Provider approval only.

4.1.9.7 If public transportation is not an option, the MCO shall ensure that the Member is provided transportation from a transportation Subcontractor.

4.1.9.7.1 [Amendment #7:] For NEMT driver services delivered on or after December 21, 2021, excluding public transit drivers, the MCO shall ensure: ~~The MCO shall be required to perform background checks on all non-emergency medical transportation providers and/or Subcontractors.~~

4.1.9.7.1.1. [Amendment #7:] Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

4.1.9.7.1.2. [Amendment #7:] Each such individual driver has a valid driver's license;

4.1.9.7.1.3. [Amendment #7:] Each such provider has in place a process to address any violation of a state drug law; and

4.1.9.7.1.4. [Amendment #7:] Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider. [Consolidated Appropriations Act, 2021 (Public Law 116-260), Division CC, Title II, Section 209].

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4.1.9.8 The MCO shall assure that ninety-five percent (95%) of all Member scheduled rides for non-methadone services are delivered within fifteen (15) minutes of the scheduled pick-up time.

4.1.9.9 The MCO shall provide reports to DHHS related to NEMT requests, authorizations, trip results, service use, late rides, and cancellations, in accordance with Exhibit O.

4.2 Pharmacy Management

4.2.1 MCO and DHHS Covered Prescription Drugs

4.2.1.1 The MCO shall cover all outpatient drugs where the manufacturer has entered into the federal rebate agreement and for which DHHS provides coverage as defined in Section 1927(k)(2) of the Social Security Act [42 CFR 438.3(s)(1)], with the exception of select drugs for which DHHS shall provide coverage to ensure Member access as identified by DHHS in separate guidance. The MCO shall not include drugs by manufacturers not participating in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) Medicaid rebate program on the MCO formulary without DHHS consent.

4.2.1.2 The MCO shall pay for all prescription drugs – including specialty and office administered drugs, with the exception of those specifically indicated by DHHS as not covered by the MCO in separate guidance – consistent with the MCO's formulary and pharmacy edits and Prior Authorization criteria that have been reviewed and approved by DHHS; and are consistent with the DHHS Preferred Drug List (PDL) as described in Section 4.2.2 (MCO Formulary) below.

4.2.1.3 Current Food and Drug Administration (FDA)-approved specialty, bio-similar and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO, unless such drugs are specified in DHHS guidance as covered by DHHS.

4.2.1.4 The MCO shall pay for, when Medically Necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a "compassionate-use basis" and imported from a foreign country.

4.2.1.5 [Amendment #7:] Effective no later than April 1, 2022, the MCO shall ensure Members diagnosed with opioid use disorder, substance use disorder, and behavioral health conditions treated at CMH Program, FQHC, FQHC look-alike, and Doorway network

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facilities with integrated on-site pharmacies have immediate access to covered specialty drugs to treat related conditions.

4.2.2 MCO Formulary

4.2.2.1 DHHS shall establish the PDL and shall be the sole party responsible for negotiating rebates for drugs on the PDL.

4.2.2.2 The MCO shall use DHHS's PDL and shall not negotiate any drug rebates with pharmaceutical manufacturers for prescribed drugs on the PDL.

4.2.2.3 DHHS shall be responsible for invoicing any pharmaceutical manufacturers for federal rebates mandated under federal law and for PDL supplemental rebates negotiated by DHHS.

4.2.2.4 The MCO shall develop a formulary that adheres to DHHS's PDL for drug classes included in the PDL and is consistent with Section 4.2.1 (MCO and DHHS Covered Prescription Drugs). In the event that DHHS makes changes to the PDL, DHHS shall notify the MCO of the change and provide the MCO with 30 calendar days to implement the change.

4.2.2.5 Negative changes shall apply to new starts within thirty (30) calendar days of notice from DHHS. The MCO shall have ninety (90) calendar days to notify Members and prescribers currently utilizing medications that are to be removed from the PDL if current utilization is to be transitioned to a preferred alternative.

4.2.2.6 For any drug classes not included in the DHHS PDL, the MCO shall determine the placement on its formulary of products within that drug class, provided the MCO covers all products for which a federal manufacturer rebate is in place and the MCO is in compliance with all DHHS requirements in this Agreement.

4.2.2.7 DHHS shall maintain a uniform review and approval process through which the MCO may submit additional information and/or requests for the inclusion of additional drug or drug classes on the DHHS PDL. DHHS shall invite the MCO's Pharmacy Manager to attend meetings of the NH Medicaid DUR Board.

4.2.2.8 The MCO shall make an up-to-date version of its formulary available to all Participating Providers and Members through the MCO's website and electronic prescribing tools. The formulary shall be available to Members and Participating Providers electronically, in a machine-readable file and format, and shall, at minimum, contain information related to:

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4.2.2.8.1 Which medications are covered, including whether it is the generic and/or the brand drug; and

4.2.2.8.2 What tier each medication is on. [42 CFR 438.10(i)(1) - (3)]

4.2.2.9 The MCO shall adhere to all relevant State and federal law, including without limitation, with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, laws of 2004, Senate Bill 383-FN, Sect. IVa. A Member shall continue to be treated or, if newly diagnosed, may be treated with a non-preferred drug based on any one (1) of the following criteria:

4.2.2.9.1 Allergy to all medications within the same class on the PDL;

4.2.2.9.2 Contraindication to or drug-to-drug interaction with all medications within the same class on the PDL;

4.2.2.9.3 History of unacceptable or toxic side effects to all medications within the same class on the PDL;

4.2.2.9.4 Therapeutic failure of all medications within the same class on the PDL;

4.2.2.9.5 An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal FDA-approved indication;

4.2.2.9.6 An age-specific indication;

4.2.2.9.7 Medical co-morbidity or other medical complication that precludes the use of a preferred drug; or;

4.2.2.9.8 Clinically unacceptable risk with a change in therapy to a preferred drug. Selection by the physician of the criteria under this subparagraph shall require an automatic approval by the pharmacy benefit program.

4.2.3 Clinical Policies and Prior Authorizations

4.2.3.1 The MCO, including any pharmacy Subcontractors, shall establish a pharmacy Prior Authorization program that includes Prior Authorization criteria and other POS edits (such as prospective DUR edits and dosage limits), and complies with Section 1927(d)(5) of the Social Security Act [42 CFR 438.3(s)(6)] and any other applicable State and federal laws, including House Bill 517, as further described in Section 4.11.1.15 (Prior Authorization).

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4.2.3.2 The MCO's pharmacy Prior Authorization criteria, including any pharmacy policies and programs, shall be submitted to DHHS prior to the implementation of this Agreement, shall be subject to DHHS approval, and shall be submitted to DHHS prior to the MCO's implementation of a modification to the criteria, policies, and/or programs.

4.2.3.3 The MCO's pharmacy Prior Authorization criteria shall meet the requirements related to Substance Use Disorder, as outlined in Section 4.11.6.15 (Limitations on Prior Authorization Requirements) of this Agreement. Under no circumstances shall the MCO's Prior Authorization criteria and other POS edits or policies depart from these requirements.

4.2.3.3.1 Additionally, specific to Substance Use Disorder, the MCO shall offer a pharmacy mail order opt-out program that is designed to support Members in individual instances where mail order requirements create an unanticipated and unique hardship. The opt-out program shall not apply to specialty pharmacy.

4.2.3.3.2 The MCO shall conduct both prospective and retrospective DUR for all Members receiving MAT for Substance Use Disorder to ensure that Members are not receiving opioids and/or benzodiazepines from other health care Providers while receiving MAT.

4.2.3.3.3 The retrospective DUR shall include a review of medical claims to identify Members that are receiving MAT through physician administered drugs (such as methadone, vivitrol, etc.).

4.2.3.4 The MCO shall make available on its website information regarding any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the DHHS-approved modification effective date.

4.2.3.5 Further, the MCO shall notify all Members and Participating Providers impacted by any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the DHHS-approved modification effective date.

4.2.3.6 [Amendment #2:] The MCO shall implement and operate a DUR program that shall be in compliance with Section 1927(g) of the Social Security Act, address Section 1004 provisions of the SUPPORT for Patient and Communities Act, and include:

4.2.3.6.1 Prospective DUR;

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4.2.3.6.2 Retrospective DUR; and

4.2.3.6.3 [Amendment #2:] An educational program for Participating Providers, including prescribers and dispensers; and [42 CFR 456, subpart K; 42 CFR 438.3(s)(4)]

4.2.3.6.4 [Amendment #2:] DUR program features in accordance with Section 1004 provisions of the SUPPORT for Patient and Communities Act, including:

4.2.3.6.4.1. [Amendment #2:] Safety edit on days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates fills of opioids in excess of limitations identified by the State;

4.2.3.6.4.2. [Amendment #2:] Safety edits on the maximum daily morphine equivalent for treatment of pain and a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;

4.2.3.6.4.3. [Amendment #2:] A claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

4.2.3.6.4.4. [Amendment #2:] A program to monitor and manage the appropriate use of antipsychotic medications by all children including foster children enrolled under the State plan;

4.2.3.6.4.5. [Amendment #2:] Fraud and abuse identification processes that identifies potential fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies; and

4.2.3.6.4.6. [Amendment #2:] Operate like the State's Fee-for-Service DUR program. [42 CFR 456, subpart K; 42 CFR 438.3(s)(4)].

4.2.3.7 The MCO shall submit to DHHS a detailed description of its DUR program prior to the implementation of this Agreement and, if the MCO's DUR program changes, annually thereafter.

4.2.3.7.1 In accordance with Section 1927 (d)(5)(A) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request

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for Prior Authorization one hundred percent (100%) of the time and reimburse for the dispensing of at least a seventy two (72) hour supply of a covered outpatient prescription drug in an emergency situation when Prior Authorization cannot be obtained. [42 CFR 438.210(d)(3)]

4.2.3.8 The MCO shall develop and/or participate in other State of New Hampshire pharmacy-related quality improvement initiatives, as required by DHHS and in alignment with the MCO's QAPI, further described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

4.2.3.8.1 [Amendment #8:] Beginning with calendar year 2022, for the HEDIS Measure "Use of Opioids from Multiple Providers", the MCO shall achieve performance that is less than or equal to the average rate of New England HMO Medicaid health plans as reported by NCQA Quality Compass for the previous calendar year.

4.2.3.9 The MCO shall institute a Pharmacy Lock-In Program for Members, which has been reviewed by DHHS, and complies with requirements included in Section 4.11.6.15 (Limitations on Prior Authorization Requirements). If the MCO determines that a Member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to Members regarding the Pharmacy Lock-In determination. The MCO may, provided the MCO receives prior approval from DHHS, implement Lock-In Programs for other medical services.

4.2.3.10 [Amendment #6:] Members shall not be required to change covered prescription drugs more than once per calendar year, with the following exceptions:

4.2.3.10.1 [Amendment #6:] When a Member is new to Medicaid, or switches from one Medicaid MCO to another Medicaid MCO;

4.2.3.10.2 [Amendment #6:] When a covered prescription drug change is initiated by the Member's provider;

4.2.3.10.3 [Amendment #6:] When a biosimilar becomes available to the market;

4.2.3.10.4 [Amendment #6:] When FDA boxed warnings or new clinical guidelines are recognized by CMS;

4.2.3.10.5 [Amendment #6:] When a covered prescription drug is withdrawn from the market because it has been found to be unsafe or removed for another reason; and

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4.2.3.10.6 [Amendment #6:] When a covered prescription is not available due to a supply shortage.

4.2.4 Systems, Data, and Reporting Requirements

4.2.4.1 Systems Requirements

4.2.4.1.1 The MCO shall adjudicate pharmacy claims for its Members using a POS system where appropriate. System modifications include, but are not limited to:

4.2.4.1.1.1. Systems maintenance,

4.2.4.1.1.2. Software upgrades, and

4.2.4.1.1.3. National Drug Code sets, or migrations to new versions of National Council for Prescription Drug Programs (NCPDP).

4.2.4.1.2 Transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated determination during the POS transaction; in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

4.2.4.2 Data and Reporting Requirements

4.2.4.2.1 To demonstrate its compliance with the DHHS PDL, the MCO shall submit to DHHS information regarding its PDL compliance rate.

4.2.4.2.2 In accordance with changes to rebate collection processes in the Affordable Care Act, DHHS shall be responsible for collecting OBRA 90 CMS rebates, inclusive of supplemental, from drug manufacturers on MCO pharmacy claims.

4.2.4.2.3 [Amendment #2:] The MCO shall provide all necessary pharmacy Encounter Data to the State to support the rebate billing process and the MCO shall submit the Encounter Data file within ~~seven (7)~~ fourteen (14) calendar days of claim payment. The Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement.

4.2.4.2.4 The drug utilization information reported to DHHS shall, at a minimum, include information on:

4.2.4.2.4.1. The total number of units of each dosage form,

4.2.4.2.4.2. Strength, and

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4.2.4.2.4.3. Package size by National Drug Code of each covered outpatient drug dispensed, per DHHS encounter specifications. [42 CFR 438.3(s)(2); Section 1927(b) of the Social Security Act]

4.2.4.2.5 The MCO shall establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization reports provided to DHHS. [42 CFR 438.3(s)(3)]

4.2.4.2.6 The MCO shall implement a mechanism to prevent duplicate discounts in the 340B Drug Pricing Program.

4.2.4.2.7 The MCO shall work cooperatively with the State to ensure that all data needed for the collection of CMS and supplemental rebates by the State's pharmacy benefit administrator is delivered in a comprehensive and timely manner, inclusive of any payments made for Members for medications covered by other payers.

4.2.4.2.8 The MCO shall adhere to federal regulations with respect to providing pharmacy data required for DHHS to complete and submit to CMS the Annual Medicaid DUR Report. [42 CFR 438.3(s)(4),(5)]

4.2.4.2.9 The MCO shall provide DHHS reporting regarding pharmacy utilization, polypharmacy, authorizations and the Pharmacy Lock-In Program, medication management, and safety monitoring of psychotropics in accordance with Exhibit O.

4.2.4.2.10 The MCO shall provide to DHHS detailed information regarding providing PCPs and behavioral health Providers access to their patients' pharmacy data and for providing prescriber information to the State PDMP. This data shall be provided in a manner prescribed by DHHS as permitted by State and federal law.

4.2.5 Medication Management

4.2.5.1 Medication Management for All Members

4.2.5.1.1 [Amendment #5:] The MCO shall at least annually conduct Comprehensive Medication Review (CMR) and counseling by a pharmacist or other health care professional to adult and child Members with polypharmacy in accordance with separate guidance.

4.2.5.1.2 In the event the Member does not respond to the MCO's offer to provide medication review and counseling, the MCO shall continue to attempt to provide such services to the Member at least

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monthly or until the Member actively accepts or denies receipt of Medication Management Services.

4.2.5.1.2.1. [Amendment #5:] The MCO shall provide comprehensive medication review and counseling to any Member upon request.

4.2.5.1.3 Polypharmacy is defined as:

4.2.5.1.3.1. Adult members dispensed five (5) or more maintenance drugs based on Generic Product Identifier (GPI) 10 or an equivalent product identification code over a sixty (60) day period (or the equivalent of five (5) maintenance drugs over a sixty (60) day period, for drugs dispensed for several months at a time); and

4.2.5.1.3.2. Child members dispensed four (4) or more maintenance drugs based on GPI 10 or an equivalent product identification code over a sixty (60) day period (or the equivalent of four (4) maintenance drugs over a sixty (60) day period, for drugs dispensed for several months at a time).

4.2.5.1.4 CMR is defined as a systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber. The counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider and is designed to improve patients' knowledge of their prescriptions, over-the-counter medications, herbal therapies and dietary supplements, identify and address problems or concerns that patients may have, and empower patients to self-manage their medications and their health conditions.

4.2.5.1.5 The MCO shall routinely monitor and address the appropriate use of behavioral health medications in children by encouraging the use of, and reimbursing for consultations with, child psychiatrists.

4.2.5.1.6 The MCO may, for purposes of satisfying Medication Management requirements, permit a Subcontract with retail-dispensing pharmacist(s) or another alternative that is also an appropriately credentialed and licensed professional approved by DHHS as part of a medication therapy management program,

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provided that the MCO ensures that the retail-dispensing pharmacist or approved alternative has access to all Member dispensing information, the MCO retains final oversight and accountability, and the MCO receives DHHS review prior to implementation of the program.

4.2.5.2 Medication Management for Children with Special Health Care Needs

4.2.5.2.1 The MCO shall be responsible for active and comprehensive medication management for Children with Special Health Care Needs. The MCO shall offer to Members, their parents, and/or caregivers, comprehensive medication management services for Children with Special Health Care Needs. If comprehensive medication management services for Children with Special Health Care Needs are accepted, the MCO shall develop active and comprehensive medication management protocols for Children with Special Health Care Needs that shall include, but not be limited to, the following:

4.2.5.2.1.1. Performing or obtaining necessary health assessments;

4.2.5.2.1.2. Formulating a medication treatment plan according to therapeutic goals agreed upon by prescriber and the Member, parent and caregiver;

4.2.5.2.1.3. Selecting, initiating, modifying, recommending changes to, or administering medication therapy;

4.2.5.2.1.4. Monitoring, which could include lab assessments and evaluating Member's response to therapy;

4.2.5.2.1.5. Consulting with social service agencies on medication management services;

4.2.5.2.1.6. Initial and on-going CMR to prevent medication-related problems and address drug reconciliation, including adverse drug events, followed by targeted medication reviews;

4.2.5.2.1.7. Documenting and communicating information about care delivered to other appropriate health care Providers;

4.2.5.2.1.8. Member education to enhance understanding and appropriate use of medications; and

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4.2.5.2.1.9. Coordination and integration of medication therapy management services with broader health Care Management services to ensure access to Medically Necessary medications wherever Member is placed, including access to out of network pharmacies.

4.2.5.2.1.10. Review of medication use shall be based on the following:

- 4.2.5.2.1.10.1 Pharmacy claims;
- 4.2.5.2.1.10.2 Provider progress reports;
- 4.2.5.2.1.10.3 Comprehensive Assessments and care plans;
- 4.2.5.2.1.10.4 Contact with the Member's Providers;
- 4.2.5.2.1.10.5 Current diagnoses;
- 4.2.5.2.1.10.6 Current behavioral health functioning;
- 4.2.5.2.1.10.7 Information from the family, Provider, DHHS and residential or other treatment entities or Providers; and
- 4.2.5.2.1.10.8 Information shared, to the extent permissible by State and federal law, with DCYF around monitoring and managing the use of psychotropic medications for children in State custody/guardianship.

4.3 Member Enrollment and Disenrollment

4.3.1 Eligibility

4.3.1.1 DHHS has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether the individual shall be enrolled in the MCM program. The MCO shall comply with eligibility decisions made by DHHS.

4.3.1.2 The MCO and its Subcontractors shall ensure that ninety-nine percent (99%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. The MCO shall develop a plan to ensure the provision of pharmacy benefits in the event the eligibility file is not successfully loaded. The MCO shall make DHHS aware, within one (1) business day, of unsuccessful uploads that go beyond twenty-four (24) hours.

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4.3.1.3 The Accredited Standards Committee (ASC) X12 834 enrollment file shall limit enrollment history to eligibility spans reflective of any assignment of the Member with the MCO.

4.3.1.4 To ensure appropriate Continuity of Care, DHHS shall provide up to six (6) months (as available) of all FFS paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all FFS Medicaid Members assigned to the MCO. For Members transitioning from another MCO, DHHS shall also provide such claims data as well as available encounter information regarding the Member supplied by other MCOs.

4.3.1.5 The MCO shall notify DHHS within five (5) business days when it identifies information in a Member's circumstances that may affect the Member's eligibility, including changes in the Member's residence, such as out-of-state claims, or the death of the Member. [42 CFR 438.608(a)(3)]

4.3.1.6 [Amendment #5:] In accordance with separate guidance, the MCO shall outreach to Members thirty (30) calendar days prior to each Member's Medicaid eligibility expiration date to assist the Member with completion and submission of required paperwork. The MCO shall be required to submit their outbound call protocols for DHHS review during the Readiness Review process.

4.3.1.6.1 [Amendment #5:] In accordance with separate guidance, the MCO shall provide support to unwind the Public Health Emergency as may be requested.

4.3.1.6.1.1. [Amendment #8:] The MCO shall take reasonable steps to support its Members prior to and during the Public Health Emergency continuous enrollment unwind period to maintain coverage for eligible beneficiaries, and promote smooth transitions for Members no longer eligible for Medicaid or other coverage.

4.3.1.6.1.2. [Amendment #8:] The MCO shall not conduct outreach to address the backlog of pending Medicaid eligibility cases to Members in a manner that would constitute a violation of federal law, including, but not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Further, compliance with these laws includes providing reasonable

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accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits. [CMS State Health Official Letter, SHO #22-001: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency. March 3, 2022]

4.3.2 [Amendment #3:] Intentionally Left Blank

[Amendment #3:] MCO Role in Work and Community Engagement Requirements for Granite Advantage Members

4.3.2.1 [Amendment #3:] ~~The MCO shall support the implementation and ongoing operations of the work and community engagement eligibility requirements for certain Granite Advantage Members, including but not limited to the activities described in Section 4.3.3 (General Outreach and Member Education Activities) through 4.3.3.2.3 (Status Tracking and Targeted Outreach) of this Agreement.~~

4.3.3 [Amendment #3:] Intentionally Left Blank

[Amendment #3:] General Outreach and Member Education Activities

4.3.3.1 [Amendment #3:] ~~The MCO shall provide general outreach and education to Granite Advantage Members regarding work and community engagement requirements set forth in the Granite Advantage waiver program and State administrative rules. MCO responsibilities include the following:~~

4.3.3.1.1 [Amendment #3:] ~~The MCO shall require that Member Services staff participate in DHHS training on work and community engagement requirements;~~

4.3.3.1.2 [Amendment #3:] ~~The MCO shall modify all Member Services call center scripts and Member Handbooks to provide information and assistance related to work and community engagement requirements;~~

4.3.3.1.3 [Amendment #3:] ~~In instances in which a Granite Advantage Member contacts the MCO for any reason, the MCO shall:~~

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~~4.3.3.1.3.1. [Amendment #3:] Inquire as to the Member's awareness of the community engagement requirement;~~

~~4.3.3.1.3.2. [Amendment #3:] Inquire as to the Member's awareness of frailty and other exemptions;~~

~~4.3.3.1.3.3. [Amendment #3:] Inquire as to the Member's awareness of their exemption status;~~

~~4.3.3.1.3.4. [Amendment #3:] Inquire as to the Member's awareness of qualifying activities and good cause exemptions if the Member's community engagement participation is mandatory;~~

~~4.3.3.1.3.5. [Amendment #3:] Explain how to satisfy the community engagement requirements, including the reporting requirements if the Member's community engagement participation is mandatory;~~

~~4.3.3.1.3.6. [Amendment #3:] Coordinate with DHHS to directly connect the Granite Advantage Member to DHHS after speaking with DHHS to accept the call ("warm transfer"); and~~

~~4.3.3.1.3.7. [Amendment #3:] Report these activities in accordance with Exhibit O.~~

~~4.3.3.1.4 [Amendment #3:] The MCO shall participate in and support additional outreach and education initiatives related to work and community engagement requirements for Granite Advantage Members as defined by DHHS.~~

~~4.3.3.2 [Amendment #3:] Member Support Services~~

~~4.3.3.2.1 [Amendment #3:] The MCO shall provide Granite Advantage Members with support related to work and community engagement requirements, including:~~

~~4.3.3.2.1.1. [Amendment #3:] Assistance with DHHS processes for reporting compliance, obtaining good cause or other exemptions; in the event a Member contacts the MCO seeking to report his/her compliance with work requirements or obtain a good cause or other exemption, the MCO shall help the Member navigate DHHS's process for demonstrating such compliance and/or exemption;~~

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~~4.3.3.2.1.2. [Amendment #3:] Connection to other sources of coverage, when applicable. As indicated in the Special Terms and Conditions of the Granite Advantage waiver approved by CMS, in the event the Member becomes ineligible for Medicaid coverage due to the work requirement, the MCO is required to support the State in the screening of eligibility for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 435.916(f).~~

~~4.3.3.2.1.3. [Amendment #3:] Providing information on options for Members to satisfy the work and community engagement requirements.~~

4.3.3.2.2 [Amendment #3:] Identification of Exempt or Potentially Exempt Members

~~4.3.3.2.2.1. [Amendment #3:] The MCO shall notify DHHS, through a mechanism specified by DHHS, of any Granite Advantage Members that the MCO identifies as potentially exempt.~~

~~4.3.3.2.2.2. [Amendment #3:] The MCO shall conduct analyses of claims and Encounter Data to identify Granite Advantage Members who may be exempt from work and community engagement requirements as defined by the Granite Advantage waiver program.~~

~~4.3.3.2.2.3. [Amendment #3:] The MCO shall conduct claims analysis for all Granite Advantage Members on an ongoing basis, at the frequency defined by DHHS. The MCO shall review all sources of data that may support its understanding of Granite Advantage Members' status related to work and community engagement requirements, including but not limited to:~~

~~4.3.3.2.2.3.1 [Amendment #3:] Information regarding Members' hospitalization;~~

~~4.3.3.2.2.3.2 [Amendment #3:] Information regarding Members' diagnoses and conditions; and~~

~~4.3.3.2.2.3.3 [Amendment #3:] Information regarding any circumstances that would exempt or potentially exempt a Member from being subject to work and community engagement requirements.~~

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~~4.3.3.2.2.4. [Amendment #3:] The MCO shall also monitor its Care Management systems and the Admissions, Discharge and Transfers (ADT) feed, and as applicable monitor its Subcontractors' Care Management system(s), for hospitalizations, diagnoses, or indications of circumstances that would exempt or potentially exempt Granite Advantage Members from work and community engagement requirements.~~

~~4.3.3.2.2.5. [Amendment #3:] For Granite Advantage Members identified as potentially exempt from work and community engagement requirements based on the MCO's claims and Encounter Data analysis, the MCO shall attempt to support the Member in obtaining physician certification of the exemption.~~

~~4.3.3.2.2.6. [Amendment #3:] The MCO shall transmit to DHHS, through a mechanism to be specified by DHHS, information for Members who are exempt or may be exempt.~~

~~4.3.3.2.2.7. [Amendment #3:] The MCO shall indicate to DHHS that the Granite Advantage Member is potentially exempt from work and community engagement requirements if, based on the MCO's claims analysis, physician certification, and/or Care Management data, the MCO can determine that the Member is exempt.~~

~~4.3.3.2.2.8. [Amendment #3:] The MCO shall indicate that the Member is potentially exempt if the MCO has determined that the individual meets the criteria for a diagnosis-based exemption, but the MCO has not been able to obtain the required physician certification.~~

~~4.3.3.2.3 [Amendment #3:] Status Tracking and Targeted Outreach~~

~~4.3.3.2.3.1. [Amendment #3:] The MCO shall receive from DHHS information generated via electronic file related to Granite Advantage Members' work and community engagement requirement status; for example, this information will indicate that the Granite Advantage Member is either "exempt," "mandatory compliant," or "mandatory non-compliant" with the work and community engagement requirements. The MCO~~

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shall be able to receive and process new information in the format designated by DHHS.

4.3.3.2.4 [Amendment #3:] ~~For Granite Advantage Members identified by DHHS as "mandatory non-compliant," the MCO shall perform targeted outreach activities and provide assistance designed to support the Member in becoming compliant with requirements to avoid coverage suspension or termination, as specified by DHHS.~~

4.3.3.2.5 [Amendment #3:] ~~The MCO's outreach to "mandatory non-compliant" Granite Advantage Members shall include, but is not limited to:~~

4.3.3.2.5.1. [Amendment #3:] ~~Telephonic outreach, including outreach above and beyond the initial Member welcome call;~~

4.3.3.2.5.2. [Amendment #3:] ~~Distribution of DHHS-approved mailings or other educational materials; and/or~~

4.3.3.2.5.3. [Amendment #3:] ~~Transmittal of electronic notification(s), including text messaging.~~

4.3.3.2.6 [Amendment #3:] ~~During periods of Member suspension of eligibility due to non-compliance with community engagement requirements or failure to receive an exemption, the MCO shall continue outreach to the suspended Member to assist the Member in completing requirements during the period before final termination of the Member's eligibility.~~

4.3.4 Enrollment

4.3.4.1 Pursuant to 42 CFR 438.54, Members who do not select an MCO as part of the Medicaid application process shall be auto-assigned to an MCO. All newly eligible Medicaid Members shall be given ninety (90) calendar days to either remain in the assigned MCO or select another MCO, if they choose. Members may not change from one (1) MCO to another outside the ninety (90) day plan selection period unless they meet the "cause" criteria as described in Section 4.3.7 (Disenrollment) of this Agreement.

4.3.4.2 The MCO shall accept all Members who choose to enroll in or who were assigned to the MCO by DHHS. The MCO shall accept for automatic re-enrollment Members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less. [42 CFR 438.56(g)]

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4.3.4.2.1 [Amendment #8:] Beginning July 1, 2022, the MCO shall accept temporarily auto re-enrolled Members into their managed care plan after the individual's loss of Medicaid coverage for a period of 120 days or less. The temporary auto re-enrollment mechanism shall remain effective until 17 months after the end of the month in which the public health emergency for COVID-19 ends as declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. § 247d). [Section 1902(e)(14) of the Act]

4.3.4.3 The MCO shall permit each Member to choose a PCP to the extent possible and appropriate. [42 CFR 438.3(l)] In instances in which the Member does not select a PCP at the time of enrollment, the MCO shall assign a PCP to the Member.

4.3.4.4 When assigning a PCP, the MCO shall include the following methodology, if information is available: Member claims history; family member's Provider assignment and/or claims history; geographic proximity; special medical needs; and language/cultural preference.

4.3.5 Non-Discrimination

4.3.5.1 The MCO shall accept new enrollment from individuals in the order in which they apply, without restriction, unless authorized by CMS. [42 CFR 438.3(d)(1)]

4.3.5.2 The MCO shall not discriminate against eligible persons or Members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions. [42 CFR 438.3(d)(3)]

4.3.5.3 The MCO shall not discriminate in enrollment, disenrollment, and re-enrollment against individuals on the basis of health status or need for health care services. [42 CFR 438.3(q)(4)]

4.3.5.4 The MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and shall not use any policy or practice that has a discriminatory effect. [42 CFR 438.3(d)(4)]

4.3.5.5 In accordance with RSA 354-A and all other relevant State and federal laws, the MCO shall not discriminate on the basis of gender identity.

4.3.6 Auto-Assignment

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4.3.6.1 [Amendment #9:] In its sole discretion, DHHS shall consider Opioid Treatment Program (OTP) resolution before using ~~use~~ the following factors for auto-assignment in an order to be determined by DHHS:

4.3.6.1.1 Preference to an MCO with which there is already a family affiliation;

4.3.6.1.2 Previous MCO enrollment, when applicable;

4.3.6.1.3 [Amendment #5:] Provider-Member relationship, to the extent obtainable and pursuant to 42 CFR 438 54(d)(7); ~~and~~

4.3.6.1.4 [Amendment #5:] Any members earned through the Performance-Based Auto-Assignment Program; ~~and~~

4.3.6.1.5 [Amendment #5:] Equitable distribution among the MCOs.

4.3.6.2 [Amendment #5:] Beginning in January 2021, DHHS shall reward one or more MCOs with membership auto-assignment in accordance with separate Performance-Based Auto-Assignment Program Guidance. Program features include:

~~[Base Contract:] DHHS may revise its auto-assignment methodology to reward those MCOs that demonstrate superior performance on one (1) or more key dimensions of performance as determined by DHHS. The implementation of a performance factor shall be at DHHS's discretion and would potentially precede the equitable distribution factor.~~

4.3.6.2.1 [Amendment #5:] Award(s) of additional membership to eligible high-performing MCO(s) based on performance.

4.3.6.2.2 [Amendment #8:] [Amendment #6:] [Amendment #5:] Membership awards described in separate guidance may include, but are not limited to the following preferential auto-assignment awards by distribution period for high-performing MCO(s):

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[Amendment #10:] Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)					
Distribution for Period Ending	Health Risk Assessment Completion	Encounter Data Timeliness Completeness and Quality	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Total Possible Members Awarded by Period
9/30/2023	2,000			1,000	3,000
12/31/2023	2,000		1,000		3,000
3/31/2024		1,000	1,000	1,000	3,000
6/30/2024		3,000			3,000
8/31/2024			2,000		2,000

[Amendment #8:] Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)								
Distribution Period for Quarter Ending	Health Risk Assessment Completion	Encounter Data Timeliness Completeness and Quality	30 Day Re-admissions to Inpatient Psychiatric Facility	ABD and DD Waiver Members Enrolled in MCO Care Management	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Members Discharged from the ED for a SUD Condition Who are Connected to Treatment	Total Possible Members Awarded By Quarter
3/31/2023	1,000	1,000					1,000	3,000
6/30/2023			1,000	2,000				3,000

[Amendment #6:] Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)							
Distribution Period for Quarter Ending	Health Risk Assessment Completion	Encounter Data Timeliness Completeness and Quality	Plan-adjusted Psychiatric Boarding	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Members Discharged from the ED for a SUD Condition Who are Connected to Treatment	Total Possible Members Awarded By Quarter
12/31/2021	1,000			2,000			3,000
3/31/2022		1,000		1,000	1,000		3,000

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6/30/2022			3,000				3,000
9/30/2022				1,500	1,500		3,000
12/31/2022				1,000	1,000	1,000	3,000

4.3.6.2.2.1. [Amendment #6:] Intentionally left blank
~~[Amendment #5:] Health Risk Assessment Completions (preferential auto-assignment of 1,000 members);~~

4.3.6.2.2.2. [Amendment #6:] Intentionally left blank
~~[Amendment #5:] Encounter Data Timeliness, Completeness and Quality (preferential auto-assignment of 1,000 members); and~~

4.3.6.2.2.3. [Amendment #6:] Intentionally left blank
~~[Amendment #5:] Plan-adjusted Psychiatric Boarding (preferential auto-assignment of 3,000 members).~~

4.3.6.3 [Amendment #5:] Members who meet factors described in Sections 4.3.6.1.1 through 4.3.6.1.3 shall be excluded from MCO auto-assignment awards under the program. DHHS reserves the right to change the auto-assignment process at its discretion.

4.3.6.3.4 [Amendment #5:] 4.3.6.3 DHHS reserves the right to change the auto-assignment process at its discretion.

4.3.7 Disenrollment

4.3.7.1 Member Disenrollment Request

4.3.7.1.1 A Member may request disenrollment "with cause" to DHHS at any time during the coverage year when:

4.3.7.1.1.1. The Member moves out of state;

4.3.7.1.1.2. The Member needs related services to be performed at the same time; not all related services are available within the network; and receiving the services separately would subject the Member to unnecessary risk;

4.3.7.1.1.3. Other reasons, including but not limited to poor quality of care, lack of access to services covered under the Agreement, violation of rights, or lack of access to Providers experienced in dealing with the Member's health care needs. [42 CFR 438.56(d)(2)]; or

4.3.7.1.1.4. The MCO does not cover the service the Member seeks because of moral or religious objections. [42 CFR 438.56(d)(2)(i) - (ii)]

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4.3.7.1.1.5. [Amendment #5:] For Member disenrollment requests "with cause" as described in Sections 4.3.7.1.1.2 through 4.3.7.1.1.4, the Member shall first seek redress through the MCO's grievance system.

4.3.7.1.2 A Member may request disenrollment "without cause" at the following times:

4.3.7.1.2.1. During the ninety (90) calendar days following the date of the Member's initial enrollment into the MCO or the date of the DHHS Member notice of the initial auto-assignment/enrollment, whichever is later;

4.3.7.1.2.2. For Members who have an established relationship with a PCP that is only in the network of a non-assigned MCO, the Member can request disenrollment during the first twelve (12) months of enrollment at any time and enroll in the non-assigned MCO;

4.3.7.1.2.3. Once every twelve (12) months;

4.3.7.1.2.4. During enrollment related to renegotiation and re-procurement;

4.3.7.1.2.5. For sixty (60) calendar days following an automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual enrollment/disenrollment opportunity (this provision applies to re-determinations only and does not apply when a Member is completing a new application for Medicaid eligibility); and

4.3.7.1.2.6. When DHHS imposes a sanction on the MCO. [42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i)-(iii)]

4.3.7.1.3 The MCO shall provide Members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period. The notice shall include an explanation of all of the Member's disenrollment rights as specified in this Agreement. [42 CFR 438.56(f)]

4.3.7.1.4 If a Member is requesting disenrollment, the Member (or his or her authorized representative) shall submit an oral or written request to DHHS. [42 CFR 438.56(d)(1)]

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4.3.7.1.5 The MCO shall furnish all relevant information to DHHS for its determination regarding disenrollment, within three (3) business days after receipt of DHHS's request for information.

4.3.7.1.6 [Amendment #6:] Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the Member files the request.

4.3.7.1.7 If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e); 42 CFR 438.56(d)(3); 42 CFR 438.3(q); 42 CFR 438.56(c)]

4.3.7.2 MCO Disenrollment Request

4.3.7.2.1 The MCO shall submit involuntary disenrollment requests to DHHS with proper documentation for the following reasons:

4.3.7.2.1.1. Member has established out of state residence;

4.3.7.2.1.2. Member death;

4.3.7.2.1.3. Determination that the Member is ineligible for enrollment due to being deemed part of an excluded population;

4.3.7.2.1.4. Fraudulent use of the Member identification card; or

4.3.7.2.1.5. In the event of a Member's threatening or abusive behavior that jeopardizes the health or safety of Members, staff, or Providers. [42 CFR 438.56(b)(1); 42 CFR 438.56(b)(3)]

4.3.7.2.2 The MCO shall not request disenrollment because of:

4.3.7.2.2.1. An adverse change in the Member's health status;

4.3.7.2.2.2. The Member's utilization of medical services;

4.3.7.2.2.3. The Member's diminished mental capacity;

4.3.7.2.2.4. The Member's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in

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the MCO seriously impairs the entity's ability to furnish services to either the particular Member or other Members); or

4.3.7.2.2.5. The Member's misuse of substances, prescribed or illicit, and any legal consequences resulting from substance misuse. [Section 1903(m)(2)(A)(v) of the Social Security Act; 42 CFR 438.56(b)(2)]

4.3.7.2.3 If an MCO is requesting disenrollment of a Member, the MCO shall:

4.3.7.2.3.1. Specify the reasons for the requested disenrollment of the Member; and

4.3.7.2.3.2. Submit a request for involuntary disenrollment to DHHS along with documentation and justification, for review.

4.3.7.2.4 [Amendment #6:] Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the MCO files the request.

4.3.7.2.5 If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e)]

4.3.8 Relationship with Enrollment Services

4.3.8.1 The MCO shall furnish information to DHHS or its designee to ensure that, before enrolling, the recipient receives the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

4.4 Member Services

4.4.1 Member Information

4.4.1.1 [Amendment #3:] The MCO shall perform the Member Services responsibilities contained in this Agreement for all Members, including Granite Advantage Members. ~~in accordance with DHHS guidance and the responsibilities described in Section 4.3.2.1 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members).~~

4.4.1.2 Primary Care Provider Information

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4.4.1.2.1 The MCO shall send a letter to a Member upon initial enrollment, and anytime the Member requests a new PCP, confirming the Member's PCP and providing the PCP's name, address, and telephone number.

4.4.1.3 Member Identification Card

4.4.1.3.1 The MCO shall issue an identification card to all New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment.

4.4.1.3.2 The identification card shall include, but is not limited to, the following information and any additional information shall be approved by DHHS prior to use on the identification card:

4.4.1.3.2.1. The Member's name;

4.4.1.3.2.2. The Member's DOB;

4.4.1.3.2.3. The Member's Medicaid identification number assigned by DHHS at the time of eligibility determination;

4.4.1.3.2.4. The name of the MCO;

4.4.1.3.2.5. The twenty-four (24) hours a day, seven (7) days a week toll-free Member Services telephone/hotline number operated by the MCO; and

4.4.1.3.2.6. How to file an appeal or grievance.

4.4.1.3.3 The MCO shall reissue a Member identification card if:

4.4.1.3.3.1. A Member reports a lost card;

4.4.1.3.3.2. A Member has a name change; or

4.4.1.3.3.3. Any other reason that results in a change to the information disclosed on the identification card.

4.4.1.4 Member Handbook

4.4.1.4.1 The MCO shall publish and provide Member information in the form of a Member Handbook at the time of Member enrollment in the plan and, at a minimum, on an annual basis thereafter. The Member Handbook shall be based upon the model Member Handbook developed by DHHS. [42 CFR 438.10(g)(1), 45 CFR 147.200(a); 42 CFR 438.10(c)(4)(ii)]

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4.4.1.4.2 The MCO shall inform all Members by mail of their right to receive free of charge a written copy of the Member Handbook. The MCO shall provide program content that is coordinated and collaborative with other DHHS initiatives. The MCO shall submit the Member Handbook to DHHS for review at the time it is developed as part of Readiness Review and after any substantive revisions at least thirty (30) calendar days prior to the effective date of such change.

4.4.1.4.3 The Member Handbook shall be in easily understood language, and include, but not be limited to, the following information:

4.4.1.4.3.1. General Information:

4.4.1.4.3.1.1 A table of contents;

4.4.1.4.3.1.2 How to access Auxiliary Aids and services, including additional information in alternative formats or languages [42 CFR 438.10(g)(2)(xiii) - (xvi), 42 CFR 438.10(d)(5)(i) - (iii)];

4.4.1.4.3.1.3 [Amendment #6:] DHHS developed definitions, including but not limited to: appeal, Copayment, DME, Emergency Medical Condition, emergency medical transportation, emergency room care, Emergency Services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, ~~hospital, outpatient care~~, Medically Necessary, network, Non-Participating Provider, Participating Provider, PCP, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, Provider, rehabilitation services and devices, skilled nursing care, specialist; and urgent care [42 CFR 438.10(c)(4)(i)];

4.4.1.4.3.1.4 The necessity definitions used in determining whether services will be covered;

4.4.1.4.3.1.5 A reminder to report to DHHS any change of address, as Members shall be liable for premium payments paid during period of ineligibility;

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4.4.1.4.3.1.6 Information and guidance as to how the Member can effectively use the managed care program [42 CFR 438.10(g)(2)];

4.4.1.4.3.1.7 Appointment procedures;

4.4.1.4.3.1.8 How to contact Service Link Aging and Disability Resource Center and the DHHS Medicaid Service Center that can provide all Members and potential Members choice counseling and information on managed care;

4.4.1.4.3.1.9 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including the MCO's toll-free telephone line and website, the toll-free telephone number for Member Services, the toll-free telephone number for Medical Management, and the toll-free telephone number for any other unit providing services directly to Members [42 CFR 438.10(g)(2)(xiii) - (xvi)];

4.4.1.4.3.1.10 How to access the NH DHHS Office of the Ombudsman and the NH Office of the Long Term Care Ombudsman;

4.4.1.4.3.1.11 The policies and procedures for disenrollment;

4.4.1.4.3.1.12 A description of the transition of care policies for potential Members and Members [42 CFR 438.62(b)(3)];

4.4.1.4.3.1.13 Cost-sharing requirements [42 CFR 438.10(g)(2)(viii)];

4.4.1.4.3.1.14 A description of utilization review policies and procedures used by the MCO;

4.4.1.4.3.1.15 A statement that additional information, including information on the structure and operation of the MCO plan and Physician Incentive Plans, shall be made available upon request [42 CFR 438.10(f)(3), 42 CFR 438.3(i)];

4.4.1.4.3.1.16 Information on how to report suspected fraud or abuse [42 CFR 438.10(g)(2)(xiii) - (xvi)];

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4.4.1.4.3.1.17 Information about the role of the PCP and information about choosing and changing a PCP [42 CFR 438.10(g)(2)(x)];

4.4.1.4.3.1.18 Non-Participating Providers and cost-sharing on any benefits carved out and provided by DHHS [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.1.19 How to exercise Advance Directives [42 CFR 438.10(g)(2)(xii), 42 CFR 438.3(j)];

4.4.1.4.3.1.20 Advance Directive policies which include a description of current State law. [42 CFR 438.3(j)(3)];

4.4.1.4.3.1.21 Information on the parity compliance process, including the appropriate contact information, as required by Section 4.11.4. (Parity);

4.4.1.4.3.1.22 [Amendment #3:] Intentionally left blank. Any information pertaining to Granite Advantage Members as required by Section 4.3.2.1 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members); and

4.4.1.4.3.1.23 Any restrictions on the Member's freedom of choice among Participating Providers [42 CFR 438.10(g)(2)(vi) - (vii)].

4.4.1.4.3.2. Benefits:

4.4.1.4.3.2.1 How and where to access any benefits provided, including Maternity services, Family Planning Services and NEMT services [42 CFR 438.10(g)(2)(i)-(ii), (vi - vii)].

4.4.1.4.3.2.2 Detailed information regarding the amount, duration, and scope of all available benefits so that Members understand the benefits to which they are entitled [42 CFR 438.10(g)(2)(iii) - (iv)];

4.4.1.4.3.2.3 How to access EPSDT services and component services if Members under age twenty-one (21) entitled to the EPSDT benefit are enrolled in the MCO;

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4.4.1.4.3.2.4 How and where to access EPSDT benefits delivered outside the MCO, if any [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.2.5 How transportation is provided for any benefits carved out of this Agreement and provided by DHHS [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.2.6 Information explaining that, in the case of a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO shall inform Members that the service is not covered and how Members can obtain information from DHHS about how to access those services [42 CFR 438.10(g)(2)(ii)(A) - (B), 42 CFR 438.102(b)(2)];

4.4.1.4.3.2.7 A description of pharmacy policies and pharmacy programs; and

4.4.1.4.3.2.8 How emergency care is provided, including:

4.4.1.4.3.2.8.1.1 The extent to which, and how, after hours and emergency coverage are provided;

4.4.1.4.3.2.8.1.2 What constitutes an Emergency Service and an Emergency Medical Condition;

4.4.1.4.3.2.8.1.3 The fact that Prior Authorization is not required for Emergency Services; and

4.4.1.4.3.2.8.1.4 The Member's right to use a hospital or any other setting for emergency care [42 CFR 438.10(g)(2)(v)].

4.4.1.4.3.3. Service Limitations:

4.4.1.4.3.3.1 An explanation of any service limitations or exclusions from coverage;

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4.4.1.4.3.3.2 An explanation that the MCO cannot require a Member to receive prior approval prior to choosing a family planning Provider [42 CFR 438.10(g)(2)(vii)];

4.4.1.4.3.3.3 A description of all pre-certification, Prior Authorization criteria, or other requirements for treatments and services;

4.4.1.4.3.3.4 Information regarding Prior Authorization in the event the Member chooses to transfer to another MCO and the Member's right to continue to utilize a Provider specified in a Prior Authorization for a period of time regardless of whether the Provider is participating in the MCO network;

4.4.1.4.3.3.5 The policy on referrals for specialty care and for other Covered Services not furnished by the Member's PCP [42 CFR 438.10(g)(2)(iii) - (iv)];

4.4.1.4.3.3.6 Information on how to obtain services when the Member is out-of-state and for after-hours coverage [42 CFR 438.10(g)(2)(v)]; and

4.4.1.4.3.3.7 A notice stating that the MCO shall be liable only for those services authorized by or required of the MCO.

4.4.1.4.3.4. Rights and Responsibilities:

4.4.1.4.3.4.1 Member rights and protections, outlined in Section 4.4.3 (Member Rights), including the Member's right to obtain available and accessible health care services covered under the MCO. [42 CFR 438.100(b)(2)(i) - (vi), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(b)(3)].

4.4.1.4.3.5. Grievances, Appeals, and Fair Hearings Procedures and Timeframes:

4.4.1.4.3.5.1 The right to file grievances and appeals;

4.4.1.4.3.5.2 The requirements and timeframes for filing grievances or appeals;

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4.4.1.4.3.5.3 The availability of assistance in the filing process for grievances and appeals;

4.4.1.4.3.5.4 The right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and

4.4.1.4.3.5.5 The right to have benefits continue pending the appeal or request for State fair hearing if the decision involves the reduction or termination of benefits, however, if the Member receives an adverse decision then the Member may be required to pay for the cost of service(s) furnished while the appeal or State fair hearing is pending. [42 CFR 438.10(g)(2)(xi)(A)-(E)]

4.4.1.4.4 Member Handbook Dissemination

4.4.1.4.4.1. The MCO shall mail the Member Handbook to new Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS; but no later than seven (7) calendar days after the effective date of enrollment. [42 CFR 438.10(g)(3)(i) - (iv)]

4.4.1.4.4.2. The MCO shall advise the Member in paper or electronic form that the Member Handbook information is available on the internet, and include the applicable internet address, provided that Members with disabilities who cannot access this information online are provided Auxiliary Aids and services upon request at no cost. [42 CFR 438.10(d)(3)] Alternatively, the MCO may provide the information by any other method that can reasonably be expected to result in the Member receiving that information. The MCO shall provide the Member Handbook information by email after obtaining the Member's agreement to receive the information electronically. [42 CFR 438.10(g)(3)(i) - (iv)]

4.4.1.4.4.3. The MCO shall notify all Members, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the MCO's website. [42 CFR 438.10(g)(3)(i) - (iv)] The Member information appearing on the website (also available in paper form) shall include the following, at a minimum:

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4.4.1.4.4.3.1 Information contained in the Member Handbook;

4.4.1.4.4.3.2 Information on how to file grievances and appeals;

4.4.1.4.4.3.3 Information on the MCO's Provider network for all Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers):

- (1) Names and any group affiliations;
- (2) Street addresses;
- (3) Office hours;
- (4) Telephone numbers;
- (5) [Amendment #7:] Website (whenever web presence exists) (if applicable);
- (6) Specialty (if any),
- (7) Description of accommodations offered for people with disabilities;
- (8) [Amendment #10:] The cultural and linguistic capabilities of Participating Providers, including languages (including American Sign Language (ASL)) offered by the Provider or a skilled medical interpreter at the Provider's office, ~~and whether the Provider has completed cultural competence training~~;
- (9) Gender of the Provider;
- (10) Identification of Providers that are not accepting new Members; and
- (11) Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(g)(2)(vi) - (vii)]

4.4.1.4.4.4. The MCO shall produce a revised Member Handbook, or an insert, informing Members of changes to Covered Services, upon DHHS notification of any change in Covered Services, and at least thirty

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(30) calendar days prior to the effective date of such change. This includes notification of any policy to discontinue coverage of a counseling or referral service based on moral or religious objections and how the Member can access those services. [42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4)]

4.4.1.4.4.5. [Amendment #9:] The MCO shall use Member notices, as applicable, in accordance with the model notices developed by DHHS. [42 CFR 438.10(c)(4)(ii)] For any change that affects Member rights, filing requirements, time frames for grievances, appeals, and State fair hearings, availability of assistance in submitting grievances and appeals, and toll-free numbers of the MCO grievance system resources, the MCO shall give each Member written notice of the change at least thirty (30) calendar days before the intended effective date of the change. ~~The MCO shall also notify all Members of their disenrollment rights, at a minimum, annually.~~ The MCO shall utilize notices that describe transition of care policies for Members and potential Members. [42 CFR 438.62(b)(3)]

4.4.1.5 Provider Directory

4.4.1.5.1 The MCO shall publish a Provider Directory that shall be reviewed by DHHS prior to initial publication and distribution. The MCO shall submit the draft Provider Directory and all substantive changes to DHHS for review.

4.4.1.5.2 The following information shall be in the MCO's Provider Directory for all Participating Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers):

- 4.4.1.5.2.1. Names and any group affiliations;
- 4.4.1.5.2.2. Street addresses;
- 4.4.1.5.2.3. Office hours;
- 4.4.1.5.2.4. Telephone numbers;
- 4.4.1.5.2.5. [Amendment #7:] Website (whenever web presence exists) (if applicable);
- 4.4.1.5.2.6. Specialty (if any),

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- 4.4.1.5.2.7. Gender;
- 4.4.1.5.2.8. Description of accommodations offered for people with disabilities;
- 4.4.1.5.2.9. [Amendment #8:] The cultural and linguistic capabilities of Participating Providers, including languages (including ASL) offered by the Participating Provider or a skilled medical interpreter at the Provider's office, ~~and whether the Participating Provider has completed cultural competence training;~~
- 4.4.1.5.2.10. Hospital affiliations (if applicable);
- 4.4.1.5.2.11. Board certification (if applicable);
- 4.4.1.5.2.12. Identification of Participating Providers that are not accepting new patients; and
- 4.4.1.5.2.13. Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(h)(1)(i) - (viii); 42 CFR 438.10(h)(2)]

4.4.1.5.3 The MCO shall send a letter to New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment directing the Member to the Provider Directory on the MCO's website and informing the Member of the right to a printed version of the Provider Directory upon request.

4.4.1.5.4 The MCO shall disseminate Practice Guidelines to Members and potential Members upon request as described in Section 4.8.2 (Practice Guidelines and Standards). [42 CFR 438.236(c)]

4.4.1.5.5 The MCO shall notify all Members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the MCO's website in a machine readable file and format as specified by CMS.

4.4.1.5.6 [Amendment #8:] The MCO shall update the paper copy of the Provider Directory at least monthly if the MCO does not have a mobile-enabled electronic directory, or quarterly, if the MCO has a mobile-enabled, electronic provider directory; and shall update an electronic directory no later than thirty (30) calendar days after the MCO receives updated *provider* information. [42 CFR 438.10(h)(3-4)].

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4.4.1.5.7 The MCO shall post on its website a searchable list of all Participating Providers. At a minimum, this list shall be searchable by Provider name, specialty, location, and whether the Provider is accepting new Members.

4.4.1.5.8 The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes. The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory.

4.4.1.5.9 Thirty (30) calendar days after the effective date of this Agreement or ninety (90) calendar days prior to the Program Start Date, whichever is later, the MCO shall develop and submit the draft website Provider Directory template to DHHS for review; thirty (30) calendar days prior to Program Start Date the MCO shall submit the final website Provider Directory.

4.4.1.5.10 Upon the termination of a Participating Provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify Members who received their primary care from, or was seen on a regular basis by, the terminated Provider. [42 CFR 438.10(f)(1)]

4.4.2 Language and Format of Member Information

4.4.2.1 The MCO shall have in place mechanisms to help potential Members and Members understand the requirements and benefits of the MCO. [42 CFR 438.10(c)(7)]

4.4.2.2 The MCO shall use the DHHS developed definitions consistently in any form of Member communication. The MCO shall develop Member materials utilizing readability principles appropriate for the population served.

4.4.2.3 The MCO shall provide all enrollment notices, information materials, and instructional materials relating to Members and potential Members in a manner and format that may be easily understood and readily accessible in a font size no smaller than twelve (12) point. [42 CFR 438.10(c)(1), 42 CFR 438.10(d)(6)(ii) - (iv)]

4.4.2.4 The MCO's written materials shall be developed in compliance with all applicable communication access requirements at the request of the Member or prospective Member at no cost.

4.4.2.5 Information shall be communicated in an easily understood language and format, including alternative formats and in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities or LEP.

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4.4.2.6 The MCO shall inform Members that information is available in alternative formats and how to access those formats. [42 CFR 438.10(d)(3), 42 CFR 438.10(d)(6)(i) - (iv)]

4.4.2.7 The MCO shall make all written Member information available in English, Spanish, and any other state-defined prevalent non-English languages of MCM Members. [42 CFR 438.10(d)(1)]

4.4.2.8 [Amendment #5:] All written Member information critical to obtaining services for potential enrollees shall include at the bottom, taglines printed in a conspicuously visible font size in large print, and in the non-English languages prevalent among MCM Members, to explaining the availability of written translation or oral interpretation, to understand the information provided and include the toll-free and teletypewriter (TTY)/TDD telephone number of the MCO's Member Services Center. [42 CFR 438.10(d)(3)]

4.4.2.9 [Amendment #5:] The large print tagline must be printed in a conspicuously visible font size, and shall include information on how to request Auxiliary Aids and services, including materials in alternative formats. Upon request, the MCO shall provide all written Member and potential enrollee critical to obtaining services information in large print with a font size no smaller than eighteen (18) point. [42 CFR 438.10(d)(2-3), 42 CFR 438.10(d)(6)(ii) - (iv)]

4.4.2.10 Written Member information shall include at a minimum:

- 4.4.2.10.1 Provider Directories;
- 4.4.2.10.2 Member Handbooks;
- 4.4.2.10.3 Appeal and grievance notices; and
- 4.4.2.10.4 Denial and termination notices.

4.4.2.11 The MCO shall also make oral interpretation services available free of charge to Members and potential Members for MCO Covered Services. This applies to all non-English languages, not just those that DHHS identifies as languages of other major population groups. Members shall not to be charged for interpretation services. [42 CFR 438.10(d)(4)]

4.4.2.12 The MCO shall notify Members that oral interpretation is available for any language and written information is available in languages prevalent among MCM Members; the MCO shall notify Members of how to access those services. [42 CFR 438.10(d)(4), 42 CFR 438.10(d)(5)(i) - (iii)]

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4.4.2.13 The MCO shall provide Auxiliary Aids such as TTY/TDD and ASL interpreters free of charge to Members or potential Members who require these services. [42 CFR 438.10(d)(4)] The MCO shall take into consideration the special needs of Members or potential Members with disabilities or LEP. [42 CFR 438.10(d)(5)(i) - (iii)]

4.4.3 Member Rights

4.4.3.1 The MCO shall have written policies which shall be included in the Member Handbook and posted on the MCO website regarding Member rights, such that each Member is guaranteed the right to:

4.4.3.1.1 Receive information on the MCM program and the MCO to which the Member is enrolled;

4.4.3.1.2 Be treated with respect and with due consideration for his or her dignity and privacy and the confidentiality of his or her PHI and PI as safeguarded by State rules and State and federal laws;

4.4.3.1.3 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

4.4.3.1.4 Participate in decisions regarding his/her health care, including the right to refuse treatment;

4.4.3.1.5 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

4.4.3.1.6 Request and receive a copy of his/her medical records free of charge, and to request that they be amended or corrected;

4.4.3.1.7 Request and receive any MCO's written Physician Incentive Plans;

4.4.3.1.8 Obtain benefits, including Family Planning Services and supplies, from Non-Participating Providers;

4.4.3.1.9 Request and receive a Second Opinion; and

4.4.3.1.10 Exercise these rights without the MCO or its Participating Providers treating the Member adversely. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(i)-(vi)]; 42 CFR 438.100(c); 42 CFR 438.10(f)(3); 42 CFR 438.10(g)(2)(vi) - (vii); 42 CFR 438.10(g)(2)(ix); 42 CFR 438.3(i)]

4.4.4 Member Communication Supports

4.4.4.1 The MCO shall embrace and further the concept of "every door for Members is the right door" to eliminate barriers and create a

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more flexible and responsive approach to person-centered service delivery. The MCO shall provide twenty-four (24) hours a day, seven (7) days a week supports such as PCP, behavioral health and specialist referrals, health coaching, assistance with social determinants of health, access to a nurse advice line, and a Member portal.

4.4.4.2 During the Readiness Review period, the MCO shall provide a blueprint of its Member portal for review by DHHS.

4.4.4.3 Member Call Center

4.4.4.3.1 [Amendment #5:] The MCO shall operate a toll-free NH specific call center Monday through Friday. The MCO shall submit the holiday calendar to DHHS for review and approval ninety (90) calendar days prior to the end of each calendar year.

4.4.4.3.2 The MCO shall ensure that the Member Call Center integrates support for physical and Behavioral Health Services including meeting the requirement that the MCO have a call line that is in compliance with requirements set forth in Section 4.11.1.19 (Member Service Line), works efficiently to resolve issues, and is adequately staffed with qualified personnel who are trained to accurately respond to Members. At a minimum, the Member Call Center shall be operational:

4.4.4.3.2.1. Two (2) days per week: eight (8:00) am Eastern Standard Time (EST) to five (5:00) pm EST;

4.4.4.3.2.2. Three (3) days per week: eight (8:00) am EST to eight (8:00) pm EST; and

4.4.4.3.2.3. During major program transitions, additional hours and capacity shall be accommodated by the MCO.

4.4.4.3.3 The Member Call Center shall meet the following minimum standards, which DHHS reserves the right to modify at any time:

4.4.4.3.3.1. Call Abandonment Rate: Fewer than five percent (5%) of calls shall be abandoned;

4.4.4.3.3.2. [Amendment #5:] Average Speed of Answer: Eighty-five percent (85%) ~~Ninety percent (90%)~~ of calls shall be answered with live voice within thirty (30) seconds; and

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4.4.4.3.3.3. Voicemail or answering service messages shall be responded to no later than the next business day.

4.4.4.3.4 [Amendment #5:] The MCO shall coordinate its Member Call Center with the DHHS Customer Service Center, the Member Service Line and all community-based and statewide crisis lines to include, at a minimum, the development of a warm transfer protocol for Members.

4.4.4.4 Welcome Call

4.4.4.4.1 The MCO shall make a welcome call to each New Member within thirty (30) calendar days of the Member's enrollment in the MCO.

4.4.4.4.2 The welcome call shall, at a minimum:

4.4.4.4.2.1. Assist the Member in selecting a PCP or confirm selection of a PCP;

4.4.4.4.2.2. Arrange for a wellness visit with the Member's PCP (either previously identified or selected by the Member from a list of available PCPs), which shall include:

4.4.4.4.2.2.1 Assessments of both physical and behavioral health,

4.4.4.4.2.2.2 Screening for depression, mood, suicidality, and Substance Use Disorder, and

4.4.4.4.2.2.3 Development of a health, wellness and care plan;

4.4.4.4.2.3. Include a Health Risk Assessment Screening as required in Section 4.10.2.2, or schedule the Health Risk Assessment to be conducted within the time limits identified in this Agreement;

4.4.4.4.2.4. Screen for special needs, physical and behavioral health, and services of the Member;

4.4.4.4.2.5. Answer any other Member questions about the MCO;

4.4.4.4.2.6. Ensure Members can access information in their preferred language; and

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4.4.4.4.2.7. Remind Members to report to DHHS any change of address, as Members shall be liable for premium payments paid during period of ineligibility.

4.4.4.4.3 Regardless of the completion of the welcome call, the MCO shall complete Health Risk Assessment Screenings as required in 4.10.2.2

4.4.4.5 Member Hotline

4.4.4.5.1 The MCO shall establish a toll-free Member Service automated hotline that operates outside of the Member Call Center standard hours, Monday through Friday, and at all hours on weekends and holidays.

4.4.4.5.2 The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for Members to leave messages.

4.4.4.5.3 The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages. Return voicemail calls shall be made no later than the next business day.

4.4.4.5.4 The MCO may substitute a live answering service in place of an automated system.

4.4.4.6 Program Website

4.4.4.6.1 The MCO shall develop and maintain, consistent with DHHS standards and other applicable State and federal laws, a website to provide general information about the MCO's program, its Participating Provider network, its formulary, Prior Authorization requirements, the Member Handbook, its services for Members, and its Grievance and Appeal Processes.

4.4.4.6.2 The MCO shall ensure that any PHI, PI or other Confidential Information solicited shall not be maintained, stored or captured on the website and shall not be further disclosed except as provided by this Agreement.

4.4.4.6.3 The solicitation or disclosure of any PHI, PI or other Confidential Information shall be subject to the requirements in Exhibit I, Exhibit K Exhibit N (Liquidated Damages Matrix) and all applicable State and federal laws, rules, and regulations.

4.4.4.6.4 Unless approved by DHHS and clear notice is provided to users of the website, the MCO shall not track, disclose or use site visitation for its website analytics or marketing.

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4.4.4.6.5 If the MCO chooses to provide required information electronically to Members, it shall:

4.4.4.6.5.1. Be in a format and location that is prominent and readily accessible;

4.4.4.6.5.2. Be provided in an electronic form which can be electronically retained and printed;

4.4.4.6.5.3. Be consistent with content and language requirements;

4.4.4.6.5.4. Notify the Member that the information is available in paper form without charge upon request; and

4.4.4.6.5.5. Provide, upon request, information in paper form within five (5) business days. [42 CFR 438.10(c)(6)(i) - (v)]

4.4.4.6.6 The MCO program content included on the website shall be:

4.4.4.6.6.1. Written in English, Spanish, and any other of the commonly encountered languages of Members;

4.4.4.6.6.2. Culturally appropriate;

4.4.4.6.6.3. Appropriate to the reading literacy of the population served; and

4.4.4.6.6.4. Geared to the health needs of the enrolled MCO program population.

4.4.4.6.7 The MCO's website shall be compliant with the federal DOJ "Accessibility of State and Local Government Websites to People with Disabilities."

4.4.5 Marketing

4.4.5.1 The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other Cold Call Marketing to potential Members. The MCO shall submit all MCO Marketing material to DHHS for approval before distribution.

4.4.5.2 DHHS shall identify any required changes to the Marketing Materials within thirty (30) calendar days. If DHHS has not responded to a request for review by the thirtieth calendar day, the MCO may proceed to use the submitted materials. [42 CFR 438.104(b)(1)(i) - (ii), 42 CFR 438.104(b)(1)(iv) - (v)]

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4.4.5.3 The MCO shall comply with federal requirements for provision of information that ensures the potential Member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

4.4.5.4 The MCO Marketing Materials shall not contain false or materially misleading information. The MCO shall not offer other insurance products as inducement to enroll.

4.4.5.5 The MCO shall ensure that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or DHHS. The MCO's Marketing Materials shall not contain any written or oral assertions or statements that:

4.4.5.5.1 The recipient shall enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

4.4.5.5.2 The MCO is endorsed by CMS, the State or federal government, or a similar entity. [42 CFR 438.104(b)(2)(i) - (ii)]

4.4.5.6 The MCO shall distribute Marketing Materials to the entire State. The MCO's Marketing Materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. The MCO shall not release and make public statements or press releases concerning the program without the prior consent of DHHS. [42 CFR 438.104(b)(1)(i) - (ii), 42 CFR 438.104(b)(1)(iv) - (v)]

4.4.6 Member Engagement Strategy

4.4.6.1 The MCO shall develop and facilitate an active Member Advisory Board that is composed of Members who represent its Member population.

4.4.6.2 Member Advisory Board

4.4.6.2.1 Representation on the Member Advisory Board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the MCM program.

4.4.6.2.2 The Member Advisory Board shall meet at least four (4) times per year.

4.4.6.2.3 The Member Advisory Board shall meet in-person or through interactive technology, including but not limited to a conference call or webinar and provide Member perspective(s) to influence the MCO's QAPI program changes (as further described in Section 4.12.3 (Quality Assessment and Performance Improvement Program)).

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4.4.6.2.4 All costs related to the Member Advisory Board shall be the responsibility of the MCO.

4.4.6.3 In-Person Regional Member Meetings

4.4.6.3.1 The MCO shall hold in-person regional Member meetings for two-way communication where Members can provide input and ask questions, and the MCO can ask questions and obtain feedback from Members.

4.4.6.3.2 Regional meetings shall be held at least twice each Agreement year in demographically different locations in NH. The MCO shall make efforts to provide video conferencing opportunities for Members to attend the regional meetings. If video conferencing is unavailable, the MCO shall use alternate technologies as available for all meetings.

4.4.6.3.3 [Amendment #6:] Intentionally left blank ~~The MCO shall report on the activities of these meetings including a summary of meeting dates, attendees, topics discussed and actions taken in response to Member contributions to DHHS in the MCM Comprehensive Annual Report, in accordance with Exhibit O.~~

4.4.6.3.4 [Amendment #5:] For the period January 1, 2021 through June 30, 2021, the MCO may utilize remote technologies for regional Member meetings.

4.4.6.3.4.1. [Amendment #6:] Beginning July 1, 2021, the MCO shall accommodate in-person and remote technologies for regional Member meetings.

4.4.7 Cultural and Accessibility Considerations

4.4.7.1 The MCO shall participate in DHHS's efforts to promote the delivery of services in a culturally and linguistically competent manner to all Members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [42 CFR 438.206(c)(2)]

4.4.7.2 The MCO shall ensure that Participating Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or behavioral disabilities. [42 CFR 438.206(c)(3)]

4.4.7.3 Cultural Competency Plan

4.4.7.3.1 In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how it will ensure that services are provided in a culturally and

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linguistically competent manner to all Members, including those with LEP, using qualified staff, interpreters, and translators in accordance with Exhibit O.

4.4.7.3.2 The Cultural Competency Plan shall describe how the Participating Providers, and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the each Member and protects and preserves a Member's dignity.

4.4.7.3.3 The MCO shall work with the DHHS Office of Health Equity to address cultural and linguistic considerations.

4.4.7.4 Communication Access

4.4.7.4.1 The MCO shall develop effective methods of communicating and working with its Members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as Members who have low-vision or hearing loss, and accommodating Members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

4.4.7.4.2 The MCO shall develop effective and appropriate methods for identifying, flagging in electronic systems, and tracking Members' needs for communication assistance, for health encounters including preferred spoken language for all encounters, need for interpreter, and preferred language for written information.

4.4.7.4.3 The MCO shall adhere to certain quality standards in delivering language assistance services, including using only Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators as defined in Section 2.1.104 through Section 2.1.107 (Definitions).

4.4.7.4.4 The MCO shall ensure the competence of employees providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. The MCO shall not:

4.4.7.4.4.1. Require a Member with LEP to provide his or her own interpreter;

4.4.7.4.4.2. Rely on an adult accompanying a Member with LEP to interpret or facilitate communication, except:

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4.4.7.4.4.2.1 In an emergency involving an imminent threat to the safety or welfare of the Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available, or

4.4.7.4.4.2.2 Where the Member with LEP specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;

4.4.7.4.4.3. Rely on a minor to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of a Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available; or

4.4.7.4.4.4. Rely on staff other than Qualified Bilingual/Multilingual Staff to communicate directly with Members with LEP. [45 CFR 92.201(e)]

4.4.7.4.5 The MCO shall ensure interpreter services are available to any Member who requests them, regardless of the prevalence of the Member's language within the overall program for all health plan and MCO services, exclusive of inpatient services.

4.4.7.4.6 The MCO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e. will provide meaningful access) for all Members in all situations. The most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and shall be based upon the unique needs and circumstances of each Member.

4.4.7.4.7 Accordingly, the MCO shall provide the most appropriate interpretation service possible under the circumstances. In all cases, the MCO shall provide in-person interpreter services when deemed clinically necessary by the Provider of the encounter service.

4.4.7.4.8 The MCO shall not use low-quality video remote interpreting services. In instances where the Qualified Interpreters are being provided through video remote interpreting services, the MCO's health programs and activities shall provide:

4.4.7.4.8.1. Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-

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quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;

4.4.7.4.8.2. A sharply delineated image that is large enough to display the interpreter's face and the participating Member's face regardless of the Member's body position;

4.4.7.4.8.3. A clear, audible transmission of voices; and

4.4.7.4.8.4. Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. [45 CFR 92.201(f)]

4.4.7.4.9 The MCO shall bear the cost of interpretive services and communication access, including ASL interpreters and translation into Braille materials as needed for Members with hearing loss and who are low-vision or visually impaired.

4.4.7.4.10 The MCO shall communicate in ways that can be understood by Members who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the Member's health and health care.

4.4.7.4.11 If the Member declines free interpretation services offered by the MCO, the MCO shall have a process in place for informing the Member of the potential consequences of declination with the assistance of a competent interpreter to assure the Member's understanding, as well as a process to document the Member's declination.

4.4.7.4.12 Interpreter services shall be offered by the MCO at every new contact. Every declination requires new documentation by the MCO of the offer and decline.

4.4.7.4.13 The MCO shall comply with applicable provisions of federal laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which prohibits the MCO from discriminating on the basis of race, color, or national origin.

4.4.7.4.14 As clarified by Executive Order 13166, Improving Access to Services for Persons with LEP, and resulting agency

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guidance, national origin discrimination includes discrimination on the basis of LEP. To ensure compliance with Title VI of the Civil Rights Act of 1964, the MCO shall take reasonable steps to ensure that LEP Members have meaningful access to the MCO's programs.

4.4.7.4.15 Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. The MCO is encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. Additionally, the MCO is encouraged to develop and implement a written language access plan to ensure it is prepared to take reasonable steps to provide meaningful access to each Member with LEP who may require assistance.

4.5 Member Grievances and Appeals

4.5.1 General Requirements

4.5.1.1 The MCO shall develop, implement and maintain a Grievance System under which Members may challenge the denial of coverage of, or payment for, medical assistance and which includes a Grievance Process, an Appeal Process, and access to the State's fair hearing system. [42 CFR 438.402(a); 42 CFR 438.228(a)] The MCO shall ensure that the Grievance System is in compliance with this Agreement, 42 CFR 438 Subpart F, State law as applicable, and NH Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

4.5.1.2 The MCO shall provide to DHHS a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for DHHS's review and approval during the Readiness Review period. Any proposed changes to the Grievance System shall be reviewed by DHHS thirty (30) calendar days prior to implementation.

4.5.1.3 The Grievance System shall be responsive to any grievance or appeal of Dual-Eligible Members. To the extent such grievance or appeal is related to a Medicaid service, the MCO shall handle the grievance or appeal in accordance with this Agreement.

4.5.1.4 In the event the MCO, after review, determines that the Dual-Eligible Member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the Member to the State's Health Insurance Assistance Program (SHIP), which is currently administered by Service Link Aging and Disability Resource Center.

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4.5.1.5 The MCO shall be responsible for ensuring that the Grievance System (Grievance Process, Appeal Process, and access to the State's fair hearing system) complies with the following general requirements. The MCO shall:

4.5.1.5.1 Provide Members with all reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the Member in providing written consent for appeals [42 CFR 438.406(a); 42 CFR 438.228(a)];

4.5.1.5.2 Acknowledge receipt of each grievance and appeal (including oral appeals), unless the Member or authorized Provider requests expedited resolution [42 CFR 438.406(b)(1); 42 CFR 438.228(a)];

4.5.1.5.3 Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making [42 CFR 438.406(b)(2)(i); 42 CFR 438.228(a)];

4.5.1.5.4 Ensure that decision makers take into account all comments, documents, records, and other information submitted by the Member or his or her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination [42 CFR 438.406(b)(2)(iii); 42 CFR 438.228(a)];

4.5.1.5.5 Ensure that, if deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the Member's condition or disease:

4.5.1.5.5.1. An appeal of a denial based on lack of medical necessity;

4.5.1.5.5.2. A grievance regarding denial of expedited resolutions of an appeal; or

4.5.1.5.5.3. A grievance or appeal that involves clinical issues. [42 CFR 438.406(b)(2)(ii)(A) - (C); 42 CFR 438.228(a)].

4.5.1.5.6 Ensure that Members are permitted to file appeals and State fair hearings after receiving notice that an adverse action is upheld [42 CFR 438.402(c)(1); 42 CFR 438.408].

4.5.1.6 The MCO shall send written notice to Members and Participating Providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

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4.5.1.7 The MCO shall provide information as specified in 42 CFR 438.10(g) about the Grievance System to Providers and Subcontractors at the time they enter into a contract or Subcontract. The information shall include, but is not limited to:

4.5.1.7.1 The Member's right to file grievances and appeals and requirements and timeframes for filing;

4.5.1.7.2 The Member's right to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

4.5.1.7.3 The availability of assistance with filing;

4.5.1.7.4 The toll-free numbers to file oral grievances and appeals;

4.5.1.7.5 The Member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the Member may be liable for the cost of any continued benefits; and

4.5.1.7.6 The Provider's right to appeal the failure of the MCO to pay for or cover a service.

4.5.1.8 The MCO shall make available training to Providers in supporting and assisting Members in the Grievance System.

4.5.1.9 The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. [42 CFR 438.416(a)]

4.5.1.10 At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the Member, the dates received, the dates of each review, the dates of the grievance or appeal, the resolution and the date of resolution. [42 CFR 438.416(b)(1) - (6)]

4.5.1.11 In accordance with Exhibit O, the MCO shall provide reports on all actions related to Member grievances and appeals, including all matters handled by delegated entities, including timely processing, results, and frequency of grievance and appeals.

4.5.1.12 The MCO shall review Grievance System information as part of the State quality strategy and in accordance with this Agreement and 42 CFR 438.402. The MCO shall regularly review appeals data for process improvement which should include but not be limited to reviewing:

4.5.1.12.1 Reversed appeals for issues that could be addressed through improvements in the Prior Authorization process; and

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4.5.1.12.2 Overall appeals to determine further Member and Provider education in the Prior Authorization process.

4.5.1.13 The MCO shall make such information accessible to the State and available upon request to CMS. [42 CFR 438.416(c)]

4.5.2 Grievance Process

4.5.2.1 The MCO shall develop, implement, and maintain a Grievance Process that establishes the procedure for addressing Member grievances and which is compliant with RSA 420-J:5, 42 CFR 438 Subpart F and this Agreement.

4.5.2.2 The MCO shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the MCO either orally or in writing at any time. [42 CFR 438.402(c)(1)(i) - (ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

4.5.2.3 The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:

4.5.2.3.1 The quality of care or services provided;

4.5.2.3.2 Aspects of interpersonal relationships such as rudeness of a Provider or employee;

4.5.2.3.3 Failure to respect the Member's rights;

4.5.2.3.4 Dispute of an extension of time proposed by the MCO to make an authorization decision;

4.5.2.3.5 Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated; and

4.5.2.3.6 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits in accordance with 42 CFR 438, subpart K.

4.5.2.4 The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance or within fifty-nine (59) calendar days of receipt of the grievance for grievances extended for up to fourteen (14) calendar days even if the MCO does not have all the information necessary to make the decision, for one hundred percent (100%) of Members filing a grievance. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]

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4.5.2.5 The MCO may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:

4.5.2.5.1 If the Member requests the extension; or

4.5.2.5.2 If the MCO shows that there is need for additional information and that the delay is in the Member's interest (upon State request). [42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1)]

4.5.2.6 If the MCO extends the timeline for a grievance not at the request of the Member, the MCO shall:

4.5.2.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay; and

4.5.2.6.2 Give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1)]

4.5.2.7 [Amendment #6:] If the Member requests disenrollment, then the MCO shall resolve the grievance in time to permit the disenrollment (if approved) to be effective no later than the first day of the following second month in which the Member requests disenrollment. [42 CFR 438.56(d)(5)(ii); 42 CFR 438.56(e)(1); 42 CFR 438.228(a)]

4.5.2.8 The MCO shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

4.5.2.9 Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

4.5.3 Appeal Process

4.5.3.1 The MCO shall develop, implement, and maintain an Appeal Process that establishes the procedure for addressing Member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement. The MCO shall have only one (1) level of appeal for Members. [42 CFR 438.402(b); 42 CFR 438.228(a)]

4.5.3.2 The MCO shall permit a Member, or the Member's authorized representative, or a Provider acting on behalf of the Member and with the Member's written consent, to request an appeal

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orally or in writing of any MCO action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

4.5.3.3 The MCO shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's estate. [42 CFR 438.406(b)(6)]

4.5.3.4 [Amendment #5:] The MCO shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. [42 CFR 438.402(c)(2)(ii)] The MCO shall ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm these inquiries in writing, unless the Member or the authorized Provider requests expedited resolution. [42 CFR 438.406(b)(3)] ~~An oral request for an appeal shall be followed by a written and signed appeal request unless the request is for an expedited resolution. [42 CFR 438.402(c)(3)(ii)]~~

4.5.3.5 If DHHS receives a request to appeal an action of the MCO, DHHS shall forward relevant information to the MCO and the MCO shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

4.5.3.6 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

4.5.3.7 The MCO shall permit the Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing [42 CFR 438.406(b)(4)]. The MCO shall inform the Member of the limited time available for this in the case of expedited resolution.

4.5.3.8 [Amendment #10:] The MCO shall provide the Member and the Member's representative an opportunity to receive the Member's case file, ~~including medical records, and any other documents and records considered during the Appeal Process~~ free of charge prior to the resolution and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b) - (c)]

4.5.3.9 [Amendment #7:] The MCO may offer peer-to-peer review support, with a like clinician, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should

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occur in a timely manner, and before the Provider seeks recourse through the Provider Appeal or State fair hearing process.

4.5.3.10 The MCO shall resolve one hundred percent (100%) of standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

4.5.3.11 The date of filing shall be considered either the date of receipt of an oral request for appeal or a written request for appeal from either the Member or Provider, whichever date is the earliest.

4.5.3.12 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits, in violation of 42 CFR 42 CFR 438, subpart K, may file an appeal.

4.5.3.13 If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the MCO's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

4.5.4 Actions

4.5.4.1 The MCO shall permit the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

4.5.4.1.1 Denial or limited authorization of a requested service, including the type or level of service;

4.5.4.1.2 Reduction, suspension, or termination of a previously authorized service;

4.5.4.1.3 Amendment #5: Denial, in whole or in part, of payment for a service, ~~except when denial for payment for a service is solely because the claim does not meet the definition of a "clean claim".~~ [42 CFR 438.400(b)(3)];

4.5.4.1.4 Failure to provide services in a timely manner, as defined by this Agreement;

4.5.4.1.5 Untimely service authorizations;

4.5.4.1.6 Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

4.5.4.1.7 At such times, if any, that DHHS has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one (1)

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MCO, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

4.5.5 Expedited Appeal

4.5.5.1 The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

4.5.5.2 The MCO shall inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals. [42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)]

4.5.5.3 The MCO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the MCO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

4.5.5.4 The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)] The MCO shall also make reasonable efforts to provide oral notice.

4.5.5.5 The date of filing of an expedited appeal shall be considered either an oral request for appeal or a written request from either the Member or Provider, whichever date is the earliest.

4.5.5.6 If the MCO extends the timeframes not at the request of the Member, it shall:

4.5.5.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay by providing a minimum of three (3) oral attempts to contact the Member at various times of the day, on different days within two (2) calendar days of the MCO's decision to extend the timeframe as detailed in He-W 506.08(j);

4.5.5.6.2 Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and

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inform the Member of the right to file a grievance if he or she disagrees with that decision;

4.5.5.6.3 Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i) - (iii); 42 CFR 438.408(b)(2)-(3)]

4.5.5.7 The MCO shall meet the timeframes above for one hundred percent (100%) of requests for expedited appeals.

4.5.5.8 The MCO shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

4.5.5.9 If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

4.5.5.10 The Member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

4.5.6 Content of Notices

4.5.6.1 The MCO shall notify the requesting Provider, and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [42 CFR 438.210(c); 42 CFR 438.404] Such notice shall meet the requirements of 42 CFR 438.404, except that the notice to the Provider need not be in writing.

4.5.6.2 The MCO shall utilize NCQA compliant DHHS model notices for all adverse actions and appeals. MCO adverse action and appeal notices shall be submitted for DHHS review during the Readiness Review process. Each notice of adverse action shall contain and explain:

4.5.6.2.1 The action the MCO or its Subcontractor has taken or intends to take [42 CFR 438.404(b)(1)];

4.5.6.2.2 The reasons for the action, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents; records, and other information relevant to the adverse action [42 CFR 438.404(b)(2)];

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4.5.6.2.3 The Member's or the Provider's right to file an appeal, including information on exhausting the MCO's one (1) level of appeal and the right to request a State fair hearing if the adverse action is upheld [42 CFR 438.404(b)(3); 42 CFR 438.402(b) - (c)];

4.5.6.2.4 Procedures for exercising Member's rights to file a grievance or appeal [42 CFR 438.404(b)(4)];

4.5.6.2.5 Circumstances under which expedited resolution is available and how to request it [42 CFR 438.404(b)(5)]; and

4.5.6.2.6 The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued; and the circumstances under which the Member may be required to pay the costs of these continued benefits [42 CFR 438.404(b)(6)].

4.5.6.3 The MCO shall ensure that all notices of adverse action be in writing and shall meet the following language and format requirements:

4.5.6.3.1 Written notice shall be translated for the Members who speak one (1) of the commonly encountered languages spoken by MCM Members (as defined by the State per 42 CFR 438.10(d));

4.5.6.3.2 Notice shall include language clarifying that oral interpretation is available for all languages and how to access it; and

4.5.6.3.3 Notices shall use easily understood language and format, and shall be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Members shall be informed that information is available in alternative formats and how to access those formats.

4.5.6.4 The MCO shall mail the notice of adverse action by the date of the action when any of the following occur:

4.5.6.4.1 The Member has died;

4.5.6.4.2 The Member submits a signed written statement requesting service termination;

4.5.6.4.3 The Member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction shall result;

4.5.6.4.4 The Member has been admitted to an institution where he or she is ineligible under the Medicaid State Plan for further services;

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4.5.6.4.5 The Member's address is determined unknown based on returned mail with no forwarding address;

4.5.6.4.6 The Member is accepted for Medicaid services by another state, territory, or commonwealth;

4.5.6.4.7 A change in the level of medical care is prescribed by the Member's physician;

4.5.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or

4.5.6.4.9 The transfer or discharge from a facility shall occur in an expedited fashion. [42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); section 1919(e)(7) of the Social Security Act; 42 CFR 483.12(a)(5)(i); 42 CFR 483.12(a)(5)(ii)]

4.5.7 Timing of Notices

4.5.7.1 For termination, suspension or reduction of previously authorized Medicaid Covered Services, the MCO shall provide Members written notice at least ten (10) calendar days before the date of action, except the period of advance notice shall be no more than five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable fraud by the Member. [42 CFR 438.404(c)(1); 42 CFR 431.211; 42 CFR 431.214]

4.5.7.2 In accordance with 42 CFR 438.404(c)(2), the MCO shall mail written notice to Members on the date of action when the adverse action is a denial of payment or reimbursement.

4.5.7.3 For standard service authorization denials or partial denials, the MCO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services. [42 CFR 438.210(d)(1); 42 CFR 438.404(c)(3)] An extension of up to an additional fourteen (14) calendar days is permissible, if:

4.5.7.3.1 The Member, or the Provider, requests the extension; or

4.5.7.3.2 The MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.210(d)(1)(i)-(ii); 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(4); 42 CFR 438.404(c)(6)]

4.5.7.4 When the MCO extends the timeframe, the MCO shall give the Member written notice of the reason for the decision to

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extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i)] Under such circumstance, the MCO shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii)]

4.5.7.5 For cases in which a Provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.5.7.6 The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest.

4.5.7.7 The MCO shall provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. [42 CFR 438.404(c)(5)]

4.5.8 Continuation of Benefits

4.5.8.1 The MCO shall continue the Member's benefits if:

4.5.8.1.1 The appeal is filed timely, meaning on or before the later of the following:

4.5.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action, or

4.5.8.1.1.2. The intended effective date of the MCO's proposed action;

4.5.8.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4.5.8.1.3 The services was ordered by an authorized Provider;

4.5.8.1.4 The authorization period has not expired;

4.5.8.1.5 The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice; and

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4.5.8.1.6 The Member requests extension of benefits, orally or in writing. [42 CFR 438.420(a); 42 CFR 438.420(b)(1) - (5); 42 CFR 438.402(c)(2)(ii)]

4.5.8.2 If the MCO continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one (1) of the following occurs:

4.5.8.2.1 The Member withdraws the appeal, in writing;

4.5.8.2.2 The Member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision regarding the Member's MCO appeal;

4.5.8.2.3 A State fair hearing decision adverse to the Member is made; or

4.5.8.2.4 The authorization expires or authorization service limits are met. [42 CFR 438.420(c)(1)-(3); 42 CFR 438.408(d)(2)]

4.5.8.3 If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the Member the amount paid for the services provided to the Member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services. [42 CFR 438.420(d); 42 CFR 431.230(b)]

4.5.8.4 A Provider acting as an authorized representative shall not request a Member's continuation of benefits pending appeal even with the Member's written consent.

4.5.9 Resolution of Appeals

4.5.9.1 The MCO shall resolve each appeal and provide notice, as expeditiously as the Member's health condition requires, within the following timeframes:

4.5.9.1.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services, a decision shall be made within thirty (30) calendar days after receipt of the appeal even if the MCO does not have all the information necessary to make the decision, unless the MCO notifies the Member that an extension is necessary to complete the appeal.

4.5.9.1.2 The MCO may extend the timeframes up to fourteen (14) calendar days if:

4.5.9.1.2.1. The Member requests an extension, orally or in writing, or

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4.5.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the Member's best interest; [42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1)]

4.5.9.1.3 If the MCO extends the timeframes not at the request of the Member then it shall:

4.5.9.1.3.1. Make reasonable efforts to give the Member prompt oral notice of the delay,

4.5.9.1.3.2. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1); 42 CFR 438.408(b)(3)]

4.5.9.2 Under no circumstances may the MCO extend the appeal determination beyond forty-five (45) calendar days from the day the MCO receives the appeal request even if the MCO does not have all the information necessary to make the decision.

4.5.9.3 The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily understood language.

4.5.9.4 The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Provider or Member may obtain the Utilization Management clinical review or decision-making criteria. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2)]

4.5.9.5 For notice of an expedited resolution, the MCO shall provide written notice, and make reasonable efforts to provide oral notice. [42 CFR 438.408(d)(2)(ii)]

4.5.9.6 For appeals not resolved wholly in favor of the Member, the notice shall:

4.5.9.6.1 Include information on the Member's right to request a State fair hearing;

4.5.9.6.2 How to request a State fair hearing;

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4.5.9.6.3 Include information on the Member's right to receive services while the hearing is pending and how to make the request; and

4.5.9.6.4 Inform the Member that the Member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision upholds the MCO's action. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2)]

4.5.10 State Fair Hearing

4.5.10.1 The MCO shall inform Members regarding the State fair hearing process, including but not limited to Members' right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F.

4.5.10.2 The parties to the State fair hearing include the MCO as well as the Member and his or her representative or the representative of a deceased Member's estate.

4.5.10.3 The MCO shall ensure that Members are informed, at a minimum, of the following:

4.5.10.3.1 That Members shall exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with DHHS; and

4.5.10.3.2 That if a Member does not agree with the MCO's resolution of the appeal, the Member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date of the MCO's notice of the resolution of the appeal. [42 CFR.408(f)(2)]

4.5.10.4 If the Member requests a fair hearing, the MCO shall provide to DHHS and the Member, upon request, within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.5 A Member may request an expedited resolution of a State fair hearing if the Administrative Appeals Unit (AAU) determines that the time otherwise permitted for a State fair hearing could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function, and:

4.5.10.5.1 The MCO adversely resolved the Member's appeal wholly or partially; or

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4.5.10.5.2 The MCO failed to resolve the Member's expedited appeal within seventy-two (72) hours and failed to extend the seventy-two (72)-hour deadline in accordance with 42 CFR 408(c) and He-W 506.08(i).

4.5.10.6 If the Member requests an expedited State fair hearing, the MCO shall provide to DHHS and the Member, upon request within twenty-four (24) hours, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.7 If the AAU grants the Member's request for an expedited State fair hearing, then the AAU shall resolve the appeal within three (3) business days after the Unit receives from the MCO the case file and any other necessary information. [He-W 506.09(g)]

4.5.10.8 The MCO shall appear and defend its decision before the DHHS AAU. The MCO shall consult with DHHS regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate, at no additional cost. In the event the State fair hearing decision is appealed by the Member, the MCO shall provide all necessary support to DHHS for the duration of the appeal at no additional cost.

4.5.10.9 The DHHS AAU shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.5.11 Effect of Adverse Decisions of Appeals and Hearings

4.5.11.1 If the MCO or DHHS reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. [42 CFR 438.424(a)]

4.5.11.2 If the MCO or DHHS reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal or State fair hearing were pending, the MCO shall pay for those services. [42 CFR 438.424(b)]

4.5.12 Survival

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4.5.12.1 The obligations of the MCO to fully resolve all grievances and appeals, including but not limited to providing DHHS with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

4.6 Provider Appeals

4.6.1 General

4.6.1.1 The MCO shall develop, implement, and maintain a Provider Appeals Process under which Providers may challenge any Provider adverse action by the MCO, and access the State's fair hearing system in accordance with RSA 126-A:5, VIII.

4.6.1.2 The MCO shall provide to DHHS a complete description of its Provider Appeals Process, in writing, including all policies and procedures, notices and forms; of its proposed Provider Appeals Process for DHHS's review and approval during the Readiness Review period.

4.6.1.3 Any proposed changes to the Provider Appeals Process shall be approved by DHHS at least thirty (30) calendar days in advance of implementation.

4.6.1.4 The MCO shall clearly articulate its Provider Appeals Process in the MCO's Provider manual, and reference it in the Provider agreement.

4.6.1.5 The MCO shall ensure its Provider Appeals Process complies with the following general requirements:

4.6.1.5.1 Gives reasonable assistance to Providers requesting an appeal of a Provider adverse action;

4.6.1.5.2 Ensures that the decision makers involved in the Provider Appeals Process and their subordinates were not involved in previous levels of review or decision making of the Provider's adverse action;

4.6.1.5.3 Ensures that decision makers take into account all comments, documents, records, and other information submitted by the Provider to the extent such materials are relevant to the appeal; and

4.6.1.5.4 Advises Providers of any changes to the Provider Appeals Process at least thirty (30) calendar days prior to implementation.

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4.6.2 Provider Adverse Actions

4.6.2.1 The Provider shall have the right to file an appeal with the MCO and utilize the Provider Appeals Process for any adverse action, in accordance with RSA 126-A:5, VIII, except for Member appeals or grievances described in Section 4.5 (Member Grievances and Appeals). The Provider shall have the right to file an appeal within thirty (30) calendar days of the date of the MCO's notice of adverse action to the Provider. Reasons may include, but are not limited to:

4.6.2.1.1 Action against the Provider for reasons related to program integrity;

4.6.2.1.2 Termination of the Provider's agreement before the agreement period has ended for reasons other than when DHHS, MFCU or other government agency has required the MCO to terminate such agreement;

4.6.2.1.3 Denial of claims for services rendered that have not been filed as a Member appeal; and

4.6.2.1.4 Violation of the agreement between the MCO and the Provider.

4.6.2.2 The MCO shall not be precluded from taking an immediate adverse action even if the Provider requests an appeal; provided that, if the adverse action is overturned during the MCO's Provider Appeals Process or State fair hearing, the MCO shall immediately take all steps to reverse the adverse action within ten (10) calendar days.

4.6.3 Provider Appeal Process

4.6.3.1 The MCO shall provide written notice to the Provider of any adverse action, and include in its notice a description of the basis of the adverse action, and the right to appeal the adverse action.

4.6.3.2 Providers shall submit a written request for an appeal to the MCO, together with any evidence or supportive documentation it wishes the MCO to consider, within thirty (30) calendar days of:

4.6.3.2.1 The date of the MCO's written notice advising the Provider of the adverse action to be taken; or

4.6.3.2.2 The date on which the MCO should have taken a required action and failed to take such action.

4.6.3.3 The MCO shall be permitted to extend the decision deadline by an additional thirty (30) calendar days to allow the Provider to submit evidence or supportive documentation, and for other good cause determined by the MCO.

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4.6.3.4 The MCO shall ensure that all Provider Appeal decisions are determined by an administrative or clinical professional with expertise in the subject matter of the Provider Appeal.

4.6.3.5 The MCO may offer peer-to-peer review support, with a like clinician, upon request, for Providers who receive an adverse decision from the MCO. Any such peer-to-peer review should occur in a timely manner and before the Provider seeks recourse through the Provider Appeal or State fair hearing process.

4.6.3.6 The MCO shall maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, log records shall include:

4.6.3.6.1 General description of each appeal;

4.6.3.6.2 Name of the Provider;

4.6.3.6.3 Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and

4.6.3.6.4 Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

4.6.3.7 If the MCO fails to adhere to notice and timing requirements established in this Agreement, then the Provider is deemed to have exhausted the MCO's Appeals Process and may initiate a State fair hearing.

4.6.3.8 MCO Resolution of Provider Appeals

4.6.3.8.1 [Amendment 7] The MCO shall provide written notice of resolution of the ninety-five percent (95%) Provider appeal (Resolution Notice) within thirty (30) calendar days from either the date the MCO receives the appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which the Provider's evidence is received by the MCO.

4.6.3.8.2 The Resolution Notice shall include, without limitation:

4.6.3.8.2.1 The MCO's decision;

4.6.3.8.2.2 The reasons for the MCO's decision;

4.6.3.8.2.3 The Provider's right to request a State fair hearing in accordance with RSA 126-A:5, VIII; and

4.6.3.8.2.4 For overturned appeals, the MCO shall take all steps to reverse the adverse action within ten (10) calendar days.

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4.6.3.9 State Fair Hearing

4.6.3.9.1 The MCO shall inform its Participating Providers regarding the State fair hearing process consistent with RSA 126-A:5, VIII, including but not limited to how to obtain a State fair hearing in accordance with its informing requirements under this Agreement.

4.6.3.9.2 The parties to the State fair hearing include the MCO as well as the Provider.

4.6.3.9.3 The Participating Provider shall exhaust the MCO's Provider Appeals Process before pursuing a State fair hearing.

4.6.3.9.4 If a Participating Provider requests a State fair hearing, the MCO shall provide to DHHS and the Participating Provider, upon request, within three (3) business days, all MCO-held documentation related to the Provider Appeal, including but not limited to, any transcript(s), records, or written decision(s).

4.6.3.9.5 The MCO shall consult with DHHS regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and availability of the Medical Director and/or other staff as appropriate, at no additional cost.

4.6.3.9.6 The MCO shall appear and defend its decision before the DHHS AAU. Nothing in this Agreement shall preclude the MCO from representation by legal counsel.

4.6.3.9.7 The DHHS AAU shall notify the MCO of State fair hearing determinations within sixty (60) calendar days of the date of the MCO's Notice of Resolution.

4.6.3.9.8 The MCO shall:

4.6.3.9.8.1 Not object to the State intervening in any such appeal;

4.6.3.9.8.2 Be bound by the State fair hearing determination, whether or not the State fair hearing determination upholds the MCO's Final Determination; and

4.6.3.9.8.3 Take all steps to reverse any overturned adverse action within ten (10) calendar days.

4.6.3.9.9 Reporting

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4.6.3.9.9.1. The MCO shall provide to DHHS, as detailed in Exhibit O, Provider complaint and appeal logs. [42 CFR 438.66(c)(3)]

4.7 Access

4.7.1 **Provider Network**

4.7.1.1 The MCO shall implement written policies and procedures for selection and retention of Participating Providers: [42 CFR 438.12(a)(2); 42 CFR 438.214(a)]

4.7.1.2 The MCO shall develop and maintain a statewide Participating Provider network that adequately meets all covered medical, mental health, Substance Use Disorder and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple Providers and disciplines and Equal Access to services. In developing its network, the MCO shall consider the following:

4.7.1.2.1 Current and anticipated NH Medicaid enrollment;

4.7.1.2.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the covered NH population;

4.7.1.2.3 The number and type (in terms of training and experience and specialization) of Providers required to furnish the contracted services;

4.7.1.2.4 The number of network Providers limiting NH Medicaid patients or not accepting new or any NH Medicaid patients;

4.7.1.2.5 The geographic location of Providers and Members, considering distance, travel time, and the means of transportation ordinarily used by NH Members;

4.7.1.2.6 The linguistic capability of Providers to communicate with Members in non-English languages, including oral and American Sign Language;

4.7.1.2.7 The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions;

4.7.1.2.8 Adequacy of the primary care network to offer each Member a choice of at least two (2) appropriate PCPs that are accepting new Medicaid patients;

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4.7.1.2.9 Required access standards identified in this Agreement;
and

4.7.1.2.10 Required access standards set forth by the NHID,
including RSA. 420-J; and Admin Rule 2700.

4.7.1.3 The MCO shall meet the network adequacy standards
included in this Agreement in all geographic areas in which the MCO
operates for all Provider types covered under this Agreement.

4.7.1.4 The MCO shall ensure that services are as accessible to
Members in terms of timeliness, amount, duration and scope as those
that are available to Members covered by DHHS under FFS Medicaid
within the same service area.

4.7.1.5 The MCO shall ensure Participating Providers comply with
the accessibility standards of the ADA. Participating Providers shall
demonstrate physical access, reasonable accommodations, and
accessible equipment for all Members including those with physical
or cognitive disabilities. [42 CFR 438.206(c)(3)]

4.7.1.6 The MCO shall demonstrate that there are sufficient
Participating Indian Health Care Providers (IHCPs) in the
Participating Provider network to ensure timely access to services for
American Indians who are eligible to receive services. If Members are
permitted by the MCO to access out-of-state IHCPs, or if this
circumstance is deemed to be good cause for disenrollment, the MCO
shall be considered to have met this requirement. [42 CFR
438.14(b)(1); 42 CFR 438.14(b)(5)]

4.7.1.7 The MCO shall maintain an updated list of Participating
Providers on its website in a Provider Directory, as specified in
Section 4.4.1.5 (Provider Directory) of this Agreement.

4.7.2 Assurances of Adequate Capacity and Services

4.7.2.1 The MCO's network shall have Participating Providers in
sufficient numbers, and with sufficient capacity and expertise for all
Covered Services to meet the geographic standards in Section 4.7.3
(Time and Distance Standards), the timely provision of services
requirements in Section 4.7.5 (Timely Access to Service Delivery),
Equal Access, and reasonable choice by Members to meet their
needs [42 CFR 438.207(a)].

4.7.2.2 The MCO shall submit documentation to DHHS, in the
format and frequency specified by DHHS in Exhibit O, that fulfills the
following requirements:

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4.7.2.2.1 The MCO shall give assurances and provide supporting documentation to DHHS that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DHHS's standards for access and timeliness of care. [42 CFR 438.207(a); 42 CFR 438.68; 42 CFR 438.206(c)(1)].

4.7.2.2.2 The MCO offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Members for the service area. [42 CFR 438.207(b)(1)];

4.7.2.2.3 The MCO's Participating Provider network includes sufficient family planning Providers to ensure timely access to Covered Services. [42 CFR 438.206(b)(7)];

4.7.2.2.4 The MCO is complying with DHHS's requirements for availability, accessibility of services, and adequacy of the network including pediatric subspecialists as described in Section 4.7.5.10 (Access Standards for Children with Special Health Care Needs);

4.7.2.2.5 The MCO is complying with DHHS's requirements for Substance Use Disorder treatment services as specified in Section 4.11.6 (Substance Use Disorder) and mental health services as specified in Section 4.11.5 (Mental Health), including Providers required to reduce Psychiatric Boarding; and

4.7.2.2.6 The MCO demonstrates Equal Access to services for all populations in the MCM program, as described in Section 4.7.5 (Timely Access to Service Delivery).

4.7.2.3 To permit DHHS to determine if access to private duty nursing services is increasing, as indicated by DHHS in Exhibit O, the MCO shall provide to DHHS the following information:

4.7.2.3.1 The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

4.7.2.3.2 The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

4.7.2.4 The MCO shall submit documentation to DHHS to demonstrate that it maintains an adequate network of Participating Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area, in accordance with Exhibit O:

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4.7.2.4.1 During the Readiness Review period, prior to the Program Start Date;

4.7.2.4.2 [Amendment #5:] Annually ~~Semi-annually~~; and

4.7.2.4.3 At any time there has been a significant change (as defined by DHHS) in the entity's operations that would affect adequate capacity and services, including but not limited to changes in services, benefits, geographic service area, or payments; and/or enrollment of a new population in the MCO. [42 CFR 438.207(b) - (c)].

4.7.2.5 For purposes of providing assurances of adequate capacity and services, the MCO shall base the anticipated number of Members on the "NH MCM Fifty Percent (50%) Population Estimate by Zip Code" report provided by DHHS.

4.7.3 Time and Distance Standards

4.7.3.1 At a minimum, the MCO shall meet the geographic access standards described in the Table below for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members. [42 CFR 438.68(b)(1)(i) - (viii); 42 CFR 438.68(b)(3)]

Geographic Access Standards	
Provider/Service	Requirement
PCPs (Adult and Pediatric)	Two (2) within forty (40) driving minutes or fifteen (15) driving miles
Adult Specialists	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Pediatric Specialists	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
OB/GYN Providers	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospitals	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Mental Health Providers (Adult and Pediatric)	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
Pharmacies	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles

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Geographic Access Standards	
Provider/Service	Requirement
Tertiary or Specialized Services (Trauma, Neonatal, etc.)	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
Individual/Group MLADCs	One (1) within forty-five (45) minutes or fifteen (15) miles
Substance Use Disorder Programs	One (1) within sixty (60) minutes or forty-five (45) miles.
Adult Medical Day Care	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospice	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Office-based Physical Therapy/Occupational Therapy/Speech Therapy	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

4.7.3.2 [Amendment #5:] The MCO shall report annually ~~semi-annually~~ how specific provider types meet the time and distance standards for Members in each county within NH in accordance with Exhibit O.

4.7.3.3 DHHS shall continue to assess where additional access requirements, whether time and distance or otherwise, shall be incorporated (for example, to ensure appropriate access to home health services). DHHS may provide additional guidance to the MCO regarding its network adequacy requirements in accordance with Members' ongoing access to care needs.

4.7.3.3.1 [Amendment #8:] The MCO shall contract with qualified Substance Use Disorder Providers who request to join its Participating Provider network as defined in Sections 2.1.89 and 2.1.119.1 of this Agreement pending the Substance Use Disorder Provider's agreement to the terms of the MCO's contract.

4.7.3.4 Additional Provider Standards

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Provider/Service	Requirement
MLADCs	The MCO's Participating Provider Network shall include seventy percent (70%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Opioid Treatment Programs (OTPs)	The MCO's Participating Provider Network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Buprenorphine Prescribers	The Network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Residential Substance Use Disorder Treatment Programs	The Network shall include fifty percent (50%) of all such Providers licensed and practicing in NH and no less than two (2) in any public health region unless there are less than two (2) such Providers in the region
Peer Recovery Programs	The MCO's Participating Provider Network shall include one hundred percent (100%) of all such willing Programs in NH

4.7.4 Standards for Geographic Accessibility

4.7.4.1 The MCO may request exceptions from the above-identified network standards after demonstrating its efforts to create a sufficient network of Participating Providers to meet these standards. DHHS reserves the right to approve or disapprove these requests, at its discretion.

4.7.4.2 Should the MCO, after good faith negotiations with Provider(s), be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, with the assistance of DHHS and after good faith negotiations, continue to be unable to meet geographic and timely access to service delivery standards, then for a period of up to sixty (60) calendar days after start date, Liquidated Damages, as described in Section 5.5.2 (Liquidated Damages) shall not apply.

4.7.4.3 Except within a period of sixty (60) calendar days after the start date where Liquidated Damages shall not apply, should the MCO, after good faith negotiations, be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable,

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after good faith negotiations with the assistance of DHHS, continue to be unable to meet geographic and timely access to service delivery standards DHHS may, at its discretion, provide temporary exemption to the MCO from Liquidated Damages.

4.7.4.4 At any time the provisions of this section may apply, the MCO shall work with DHHS to ensure that Members have access to needed services.

4.7.4.5 The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the Participating Provider network to ensure that necessary admissions can be made.

4.7.4.6 Exceptions

4.7.4.6.1 The MCO may request exceptions, via a Request for Exception, from the network adequacy standards after demonstrating its efforts to create a sufficient network of Participating Providers to meet these standards. [42 CFR 438.68(d)(1)] DHHS may grant the MCO an exception in the event that:

4.7.4.6.1.1. The MCO demonstrates that an insufficient number of qualified Providers or facilities that are willing to contract with the MCO are available to meet the network adequacy standards in this Agreement and as otherwise defined by the NHID and DHHS;

4.7.4.6.1.2. The MCO demonstrates, to the satisfaction of DHHS, that the MCO's failure to develop a Participating Provider network that meets the requirements is due to the refusal of a Provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

4.7.4.6.1.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from a Participating Provider that is a physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist, or other behavioral health specialists licensed by the NH Board of Medicine. [RSA 167:4-d]

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4.7.4.7 The MCO is permitted to use telemedicine as a tool for ensuring access to needed services in accordance with telemedicine coverage policies reviewed and approved by DHHS, but the MCO shall not use telemedicine to meet the State's network adequacy standards unless DHHS has specifically approved a Request for Exception.

4.7.4.8 The MCO shall report on network adequacy and exception requests in accordance with Exhibit O.

4.7.5 Timely Access to Service Delivery

4.7.5.1 The MCO shall meet the following timely access standards for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members.

4.7.5.2 The MCO shall make Covered Services available for Members twenty-four (24) hours a day, seven (7) days a week, when Medically Necessary. [42 CFR 438.206(c)(1)(iii)]

4.7.5.3 The MCO shall require that all Participating Providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial Members or are comparable to Medicaid FFS patients, if the Provider serves only Medicaid Members. [42 CFR 438.206(c)(1)(ii)].

4.7.5.4 The MCO shall encourage Participating Providers to offer after-hours office care in the evenings and on weekends.

4.7.5.5 The MCO's network shall meet minimum timely access to care and services standards as required per 42 CFR 438.206(c)(1)(i). Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

4.7.5.6 The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

4.7.5.6.1 Non-Symptomatic Office Visits (i.e., preventive care) shall be available from the Member's PCP or another Provider within forty-five (45) calendar days.

4.7.5.6.2 A Non-Symptomatic Office Visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

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4.7.5.6.3 Non-Urgent, Symptomatic Office Visits (i.e., routine care) shall be available from the Member's PCP or another Provider within ten (10) calendar days. A Non-Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms not requiring immediate attention.

4.7.5.6.4 Urgent, Symptomatic Office Visits shall be available from the Member's PCP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

4.7.5.6.5 Transitional Health Care shall be available from a primary care or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.6.6 Transitional Home Care shall be available with a home care nurse, licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or Specialty Care Provider or as part of the discharge plan.

4.7.5.7 [Amendment #7:] The MCO shall establish mechanisms to ensure that Participating Providers comply with the timely access standards. The MCO shall regularly monitor its network to determine compliance with timely access and shall provide an annual ~~a semi-annual~~ report to DHHS documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v), in accordance with Exhibit O.

4.7.5.8 The MCO shall monitor waiting times for obtaining appointments with approved CMH Programs and report case details on a semi-annual basis.

4.7.5.9 The MCO shall develop and implement a CAP if it or its Participating Providers fail to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

4.7.5.10 Access Standards for Children with Special Health Care Needs

4.7.5.10.1 The MCO shall contract with specialists that have pediatric expertise where the need for pediatric specialty care significantly differs from adult specialty care.

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4.7.5.10.2 In addition to the "specialty care" Provider network adequacy requirements, the MCO shall contract with the following pediatric specialists:

- 4.7.5.10.2.1. Pediatric Critical Care;
- 4.7.5.10.2.2. Pediatric Child Development ;
- 4.7.5.10.2.3. Pediatric Genetics;
- 4.7.5.10.2.4. Pediatric Physical Medicine and Rehabilitation;
- 4.7.5.10.2.5. Pediatric Ambulatory Tertiary Care ;
- 4.7.5.10.2.6. Neonatal-Perinatal Medicine;
- 4.7.5.10.2.7. Pediatrics-Adolescent Medicine; and
- 4.7.5.10.2.8. Pediatric Psychiatry.

4.7.5.11 The MCO shall have adequate networks of pediatric Providers, sub-specialists, children's hospitals, pediatric regional centers and ancillary Providers to provide care to Children with Special Health Care Needs.

4.7.5.12 The MCO shall specify, in their listing of mental health and Substance Use Disorder Provider directories, which Providers specialize in children's services.

4.7.5.13 The MCO shall ensure that Members have access to specialty centers in and out of NH for diagnosis and treatment of rare disorders.

4.7.5.14 The MCO shall permit a Member who meets the definition of Children with Special Health Care Needs following plan enrollment and who requires specialty services to request approval to see a Non-Participating Provider to provide those services if the MCO does not have a Participating specialty Provider with the same level of expertise available.

4.7.5.15 The MCO shall develop and maintain a program for Children with Special Health Care Needs, which includes, but is not limited to methods for ensuring and monitoring timely access to pediatric specialists, subspecialists, ancillary therapists and specialized equipment and supplies; these methods may include standing referrals or other methods determined by the MCO.

4.7.5.16 The MCO shall ensure PCPs and specialty care Providers are available to provide consultation to DCYF regarding medical and

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psychiatric matters for Members who are children in State custody/guardianship.

4.7.5.17 Access Standards for Behavioral Health

4.7.5.17.1 The MCO shall have in its network the capacity to ensure that Transitional Health Care by a Provider shall be available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.17.2 Emergency medical and behavioral health care shall be available twenty-four (24) hours a day, seven (7) days a week. Behavioral health care shall be available, and the MCO shall have in its network the capacity to ensure that waiting times for appointments and/or service availability do not exceed the following:

4.7.5.17.2.1. Within six (6) hours for a non-life threatening emergency;

4.7.5.17.2.2. Within forty-eight (48) hours for urgent care; and

4.7.5.17.2.3. Within ten (10) business days for a routine office visit appointment.

4.7.5.17.3 American Society of Addiction Medicine (ASAM) Level of Care

4.7.5.17.3.1. The MCO shall ensure Members timely access to care through a network of Participating Providers in each ASAM Level of Care. During the Readiness Review process and in accordance with Exhibit O:

4.7.5.17.3.1.1 The MCO shall submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of Substance Use Disorder service Providers so that services are accessible without unreasonable delays; and

4.7.5.17.3.1.2 The MCO shall have a specified number of Providers able to provide services at each level of care required; if supply precludes compliance, the MCO shall notify DHHS and, within thirty (30) calendar days, submit an updated plan that identifies the specific steps that shall be taken

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to increase capacity, including milestones by which to evaluate progress.

4.7.5.18 The MCO shall ensure that Providers under contract to provide Substance Use Disorder services shall respond to inquiries for Substance Use Disorder services from Members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The Substance Use Disorder Provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the Member or referring agency, but not later than two (2) business days following the date of first contact.

4.7.5.19 The MCO shall ensure that Members who have screened positive for Substance Use Disorder services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment and no later than (3) business days after admission.

4.7.5.20 The MCO shall ensure that Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed until such a time that the Member is accepted and starts receiving services by the receiving agency. Members identified for partial hospitalization or rehabilitative residential services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed.

4.7.5.21 If the type of service identified in the ASAM Level of Care Assessment is not available from the Provider that conducted the initial assessment within forty-eight (48) hours, the MCO shall ensure that the Provider provides interim Substance Use Disorder services until such a time that the Member starts receiving the identified level of care. If the type of service is not provided by the ordering Provider than the MCO is responsible for making a closed loop referral for that type of service (for the identified level of care) within fourteen (14) business days from initial contact and to provide interim Substance Use Disorder services until such a time that the Member is accepted and starts receiving services by the receiving agency.

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4.7.5.22 When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the Member's choice, Members being provided interim services shall be reassessed for ASAM level of care.

4.7.5.23 The MCO shall ensure that pregnant women are admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the MCO is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours, the MCO shall:

4.7.5.23.1 Assist the pregnant woman with identifying alternative Providers and with accessing services with these Providers. This assistance shall include actively reaching out to identify Providers on the behalf of the Member;

4.7.5.23.2 Provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week; Recovery support services as needed by the Member; and daily calls to the Member to assess and respond to any emergent needs.

4.7.5.24 Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.

4.7.6 Women's Health

4.7.6.1 The MCO shall provide Members with direct access to a women's health specialist within the network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].

4.7.6.2 The MCO shall provide access to Family Planning Services as defined in Section 2.1.47 (Definitions) to Members without the need for a referral or prior-authorization. Additionally, Members shall be able to access these services by Providers whether they are in or out of the MCO's network.

4.7.6.3 Enrollment in the MCO shall not restrict the choice of the Provider from whom the Member may receive Family Planning Services and supplies. [Section 1902(a)(23) of the Social Security Act; 42 CFR 431.51(b)(2)]

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4.7.6.4 The MCO shall only provide for abortions in the following situations:

4.7.6.4.1 If the pregnancy is the result of an act of rape or incest; or

4.7.6.4.2 In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition, caused by, or arising from, the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. [42 CFR 441.202; Consolidated Appropriations Act of 2008]

4.7.6.5 The MCO shall not provide abortions as a benefit, regardless of funding, for any reasons other than those identified in this Agreement.

4.7.7 Access to Special Services

4.7.7.1 The MCO shall ensure Members have access to DHHS-designated Level I and Level II Trauma Centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's service area or in close proximity to such service area. The MCO shall have written, out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a Trauma Center in its network.

4.7.7.2 The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, cranio-facial and congenital anomalies, home health agencies, and hospice programs. To the extent that the above specialty services are available within the State, the plan shall not exclude NH Providers from its network if the negotiated rates are commercially reasonable.

4.7.7.3 The MCO shall only pay for organ transplants when the Medicaid State Plan provides, and the MCO follows written standards that provide for similarly situated Members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Members. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act]

4.7.7.4 The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available.

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The MCO shall not exclude NH Providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

4.7.8 Non-Participating Providers

4.7.8.1 If the MCO's network is unable to provide necessary medical, behavioral health or other services covered under the Agreement to a particular Member, the MCO shall adequately and in a timely manner cover these services for the Member through Non-Participating Providers, for as long as the MCO's Participating Provider network is unable to provide them. [42 CFR 438.206(b)(4)].

4.7.8.2 The MCO shall inform the Non-Participating Provider that the Member cannot be balance billed.

4.7.8.3 The MCO shall coordinate with Non-Participating Providers regarding payment utilizing a single case agreement. For payment to Non-Participating Providers, the following requirements apply:

4.7.8.3.1 If the MCO offers the service through a Participating Provider(s), and the Member chooses to access non-emergent services from a Non-Participating Provider, the MCO is not responsible for payment.

4.7.8.3.2 If the service is not available from a Participating Provider and the Member requires the service and is referred for treatment to a Non-Participating Provider, the payment amount is a matter between the MCO and the Non-Participating Provider.

4.7.8.4 The MCO shall ensure that cost to the Member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

4.7.9 Access to Providers During Transitions of Care

4.7.9.1 The MCO shall use a standard definition of "Ongoing Special Condition" which shall be defined as follows:

4.7.9.1.1 In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

4.7.9.1.2 In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

4.7.9.1.3 In the case of pregnancy, pregnancy from the start of the second trimester.

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4.7.9.1.4 In the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

4.7.9.1.5 In the case of a child with Special Health Care Needs as defined in Section 4.10.3 (Priority Populations).

4.7.9.2 The MCO shall permit that, in the instances when a Member transitions into the MCO from FFS Medicaid, another MCO (including one that has terminated its agreement with DHHS) or another type of health insurance coverage and:

4.7.9.2.1 The Member is in ongoing course of treatment, has an Ongoing Special Condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), regardless of whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first;

4.7.9.2.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.2.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.3 The MCO shall permit that, in instances when a Member with an Ongoing Special Condition transitions into the MCO from FFS Medicaid or another MCO and at the time has a currently prescribed medication, the MCO shall cover such medications for ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first.

4.7.9.4 The MCO shall permit that, in instances in which a Provider in good standing leaves an MCO's network and:

4.7.9.4.1 The Member is in ongoing course of treatment, has a special condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days;

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4.7.9.4.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.4.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.5 The MCO shall maintain a transition plan providing for Continuity of Care in the event of Agreement termination, or modification limiting service to Members, between the MCO and any of its contracted Providers, or in the event of site closing(s) involving a PCP with more than one (1) location of service. The transition plan shall describe how Members shall be identified by the MCO and how Continuity of Care shall be provided.

4.7.9.6 The MCO shall provide written notice of termination of a Participating Provider to all affected Members, defined as those who:

4.7.9.6.1 Have received services from the terminated Provider within the sixty (60)-day period immediately preceding the date of the termination; or

4.7.9.6.2 Are assigned to receive primary care services from the terminated Provider.

4.7.9.7 [Amendment #5:] The MCO shall make a good faith effort to give written notice of termination of a contracted provider, as follows:

4.7.9.7.1 [Amendment #5:] Written notice to DHHS, the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination; and

4.7.9.7.2 [Amendment #5:] Written notice to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, the later of:

4.7.9.7.2.1. [Amendment #5:] Thirty (30) calendar days prior to the effective date of the termination; or

4.7.9.7.2.2. [Amendment #5:] Fifteen (15) calendar days after receipt or issuance of the termination notice by the terminated provider.

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4.7.9.7.2.3. [Amendment #5:] The MCO shall have a transition plan in place for affected Members described in Section 4.7.9.7 within three (3) calendar days prior to the effective date of the termination.

~~[Base Contract:] notify DHHS and affected Members in writing of a Provider termination. The notice shall be provided by the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination. Within three (3) calendar days prior to the effective date of the termination the MCO shall have a transition plan in place for all affected Members.~~

4.7.9.8 In addition to notification of DHHS of provider terminations, the MCO shall provide reporting in accordance with Exhibit O.

4.7.9.9 If a Member is in a prior authorized ongoing course of treatment with a Participating Provider who becomes unavailable to continue to provide services, the MCO shall notify the Member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a transition plan for the affected Member.

4.7.9.10 If the terminated Provider is a PCP to whom the MCO Members are assigned, the MCO shall:

4.7.9.10.1 Describe in the notice to Members the procedures for selecting an alternative PCP;

4.7.9.10.2 Explain that the Member shall be assigned to an alternative PCP if they do not actively select one; and

4.7.9.10.3 Ensure the Member selects or is assigned to a new PCP within thirty (30) calendar days of the date of notice to the Member.

4.7.9.11 If the MCO is receiving a new Member it shall facilitate the transition of the Member's care to a new Participating Provider and plan a safe and medically appropriate transition if the Non-Participating Provider refuses to contract with the MCO.

4.7.9.12 The MCO shall actively assist Members in transitioning to a Participating Provider when there are changes in Participating Providers, such as when a Provider terminates its contract with the MCO. The Member's Care Management team shall provide this assistance to Members who have chronic or acute medical or behavioral health conditions, and Members who are pregnant.

4.7.9.13 To minimize disruptions in care, the MCO shall:

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4.7.9.13.1 With the exception of Members in their second or third trimester of pregnancy, provide continuation of the terminating Provider for up to ninety (90) calendar days or until the Member may be reasonably transferred to a Participating Provider without disruption of care, whichever is less; and

4.7.9.13.2 For Members in their second or third trimester of pregnancy, permit continued access to the Member's prenatal care Provider and any Provider currently treating the Member's chronic or acute medical or behavioral health condition or currently providing LTSS, through the postpartum period.

4.7.10 Second Opinion

4.7.10.1 The MCO shall provide for a Second Opinion from a qualified health care professional within the Participating Provider network, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member [42 CFR 438.206(b)(3)]. The MCO shall clearly state its procedure for obtaining a Second Opinion in its Member Handbook.

4.7.11 Provider Choice

4.7.11.1 The MCO shall permit each Member to choose his or her Provider to the extent possible and appropriate [42 CFR 438.3(l)].

4.8 Utilization Management

4.8.1 Policies and Procedures

4.8.1.1 The MCO's policies and procedures related to the authorization of services shall be in compliance with all applicable laws and regulations including but not limited to 42 CFR 438.210 and RSA Chapter 420-E.

4.8.1.2 The MCO shall ensure that the Utilization Management program assigns responsibility to appropriately licensed clinicians, including but not limited to physicians, nurses, therapists, and behavioral health Providers (including Substance Use Disorder professionals).

4.8.1.3 Amount, Duration, and Scope

4.8.1.3.1 The MCO shall ensure that each service provided to adults is furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under FFS Medicaid. [42 CFR 438.210(a)(2)]

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4.8.1.3.2 The MCO shall also provide services for Members under the age of twenty-one (21) to the same extent that services are furnished to individuals under the age of twenty-one (21) under FFS Medicaid. [42 CFR 438.210(a)(2)] Services shall be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. [42 CFR 438.210(a)(3)(i)]

4.8.1.3.3 Authorization duration for certain Covered Services shall be as follows:

4.8.1.3.3.1. Private duty nursing authorizations shall be issued for no less than six (6) months unless the Member is new to the private duty nursing benefit. Initial authorizations for Members new to the private duty nursing benefit shall be no less than two (2) weeks;

4.8.1.3.3.1.1 [Amendment #9] [Amendment #8:] [Amendment #7:] For the period January 1, 2022 through the end of the COVID-19 Public Health Emergency June 30 December 31, 2022, in an effort to ensure that Members receive timely, necessary, and appropriate medical care requiring covered private duty nursing services that might otherwise go unmet due to expired authorizations and to ensure that providers are not penalized for providing said timely, necessary and appropriate medical care, the MCO shall not deny a private duty nursing provider's reimbursement for covered services rendered up to forty-five (45) days after the service authorization expires.

4.8.1.3.3.2. Personal Care Attendant (PCA) authorizations shall be issued for no less that one (1) year unless the Member is new to the PCA benefit. Initial authorizations for Members new to the PCA benefit shall be no less than three (3) months.

4.8.1.3.3.3. Occupational therapy, physical therapy, and speech therapy authorizations that exceed the service limit of twenty (20) visits for each type of therapy shall be issued for no less than three (3) months initially. Subsequent authorizations for continuation of therapy services shall be issued for no less than six (6) months if the therapy is for habilitative purposes directed at functional impairments.

4.8.1.4 Written Utilization Management Policies

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4.8.1.4.1 The MCO shall develop, operate, and maintain a Utilization Management program that is documented through a program description and defined structures, policies, and procedures that are reviewed and approved by DHHS. The MCO shall ensure that the Utilization Management Program has criteria and policies that:

4.8.1.4.1.1. Are practicable, objective and based on evidence-based criteria, to the extent possible;

4.8.1.4.1.2. Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the MCO's service area, and are consistent with the Practice Guidelines described in Section 4.8.2 (Practice Guidelines and Standards);

4.8.1.4.1.3. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (DHHS shall approve any changes to the clinical criteria before the criteria are utilized);

4.8.1.4.1.4. Are applied based on individual needs and circumstances (including social determinants of health needs);

4.8.1.4.1.5. Are applied based on an assessment of the local delivery system;

4.8.1.4.1.6. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

4.8.1.4.1.7. Conform to the standards of NCQA Health Plan Accreditation as required by Section 4.12.2 (Health Plan Accreditation).

4.8.1.4.2 The MCO's written Utilization Management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Such policies, procedures and criteria shall address, at a minimum:

4.8.1.4.2.1. Second Opinion programs;

4.8.1.4.2.2. Pre-hospital admission certification;

4.8.1.4.2.3. Pre-inpatient service eligibility certification;

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4.8.1.4.2.4. Concurrent hospital review to determine appropriate length of stay;

4.8.1.4.2.5. The process used by the MCO to preserve confidentiality of medical information.

4.8.1.4.3 Clinical review criteria and changes in criteria shall be communicated to Participating Providers and Members at least thirty (30) calendar days in advance of the changes.

4.8.1.4.4 The Utilization Management Program descriptions shall be submitted by the MCO to DHHS for review and approval prior to the Program Start Date.

4.8.1.4.5 Thereafter, the MCO shall report on the Utilization Management Program as part of annual reporting in accordance with Exhibit O.

4.8.1.4.6 The MCO shall communicate any changes to Utilization Management processes at least thirty (30) calendar days prior to implementation.

4.8.1.4.7 The MCO's written Utilization Management policies, procedures, and criteria shall be made available upon request to DHHS, Participating Providers, and Members.

4.8.1.4.8 The MCO shall provide the Medical Management Committee (or the MCO's otherwise named committee responsible for medical Utilization Management) reports and minutes in accordance with Exhibit O. [42 CFR 438.66 (c)(7)]

4.8.1.5 Service Limit

4.8.1.5.1 The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity [42 CFR 438.210(a)(4)(i)]; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. [42 CFR 438.210(a)(4)(ii)(A)]

4.8.1.5.2 The MCO may place appropriate limits on a service for utilization control, provided:

4.8.1.5.2.1. The services supporting Members with ongoing or Chronic Conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports [42 CFR 438.210(a)(4)(ii)(B)]. This includes allowance for up to six (6) skilled nursing visits per benefit period without a Prior Authorization; and

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4.8.1.5.2.2. Family Planning Services are provided in a manner that protects and enables the Member's freedom to choose the method of Family Planning to be used. [42 CFR 438.210(a)(4)(ii)(C)]

4.8.1.6 Prior Authorization

4.8.1.6.1 The MCO and, if applicable, its Subcontractors shall have in place and follow written policies and procedures as described in the Utilization Management policies for processing requests for initial and continuing authorizations of services and including conditions under which retroactive requests shall be considered. Any Prior Authorization for Substance Use Disorder shall comply with RSA 420-J:17 and RSA 420-J:18 as described in Section 4.11.6.15 (Limitations on Prior Authorization Requirements). [42 CFR 438.210(b)(1)]

4.8.1.6.2 Authorizations shall be based on a comprehensive and individualized needs assessment that addresses all needs including social determinants of health and a subsequent person-centered planning process. [42 CFR 438.210(b)(2)(iii)] The MCO's Prior Authorization requirements shall comply with parity in mental health and Substance Use Disorder, as described in Section 4.11.4.4 (Restrictions on Treatment Limitations). [42 CFR 438.910(d)]

4.8.1.6.3 The MCO shall use the NH MCM standard Prior Authorization form. The MCO shall also work in good faith with DHHS, as initiated by DHHS, to develop other Prior Authorization forms with consistent information and documentation requirements from Providers wherever feasible. Providers shall be able to submit the Prior Authorizations forms electronically, by mail, or fax.

4.8.1.6.4 The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including but not limited to interrater reliability monitoring, and consult with the requesting Provider when appropriate and at the request of the Provider submitting the authorization [42 CFR 438.210(b)(2)(i)-(ii)].

4.8.1.6.5 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. [42 CFR 438.210(b)(3)]

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4.8.1.6.6 The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Member.

4.8.1.6.7 The MCO shall comply with all relevant federal regulations regarding inappropriate denials or reductions in care. [42 CFR 438.210(a)(3)(ii)]

4.8.1.6.8 The MCO shall issue written denial notices within timeframes specified by federal regulations and this Agreement.

4.8.1.6.9 The MCO shall permit Members to appeal service determinations based on the Grievance and Appeal Process required by federal law and regulations and this Agreement.

4.8.1.6.10 Compensation to individuals or entities that conduct Utilization Management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member. [42 CFR 438.210(e)]

4.8.1.6.11 Medicaid State Plan services and/or pharmaceutical Prior Authorizations, including those for specialty drugs, in place at the time a Member transitions to an MCO shall be honored for ninety (90) calendar days or until completion of a medical necessity review, whichever comes first.

4.8.1.6.12 The MCO shall, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.

4.8.1.6.13 Upon receipt of Prior Authorization information from DHHS, the new MCO shall honor Prior Authorizations in place by the former MCO as described in Section 4.7.9. (Access to Providers During Transitions of Care). The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 4.8.4.2 (Urgent Determinations and Covered/Extended Services).

4.8.1.6.14 ~~[Amendment #9] Intentionally left blank. The MCO shall also, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.~~

4.8.1.6.15 In the event that the Prior Authorization specifies a specific Provider, that MCO shall continue to utilize that Provider, regardless of whether the Provider is a Participating Provider, until such time as services are available in the MCO's network.

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4.8.1.6.16 The MCO shall ensure that the Member's needs are met continuously and shall continue to cover services under the previously issued Prior Authorization until the MCO issues new authorizations that address the Member's needs.

4.8.1.6.17 The MCO shall ensure that Subcontractors or any other party performing utilization review are licensed in NH in accordance with Section 3.14.2. (Contracts with Subcontractors).

4.8.1.6.18 [Amendment #8:] Beginning July 1, 2022, the MCO shall ensure that Subcontractors or any other party performing utilization reviews applicable to inpatient psychiatric treatment at New Hampshire Hospital and other State determined IMDs for mental illness, conduct authorization for services as follows:

4.8.1.6.18.1. [Amendment #8:] For a Member's initial admission, an automatic five (5) business days (excluding holidays) shall be authorized for the Member's initial involuntary emergency psychiatric admission to an IMD facility.

4.8.1.6.18.2. [Amendment #8:] Reauthorization of the Member's continuous admission, shall be rendered promptly within 24 hours of the request for reauthorization of the initial involuntary emergency psychiatric admission.

4.8.2 Practice Guidelines and Standards

4.8.2.1 The MCO shall adopt evidence-based clinical Practice Guidelines in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines adopted by the MCO shall:

4.8.2.1.1 Be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field,

4.8.2.1.2 Consider the needs of the MCO's Members,

4.8.2.1.3 Be adopted in consultation with Participating Providers, and

4.8.2.1.4 Be reviewed and updated periodically as appropriate. [42 CFR 438.236(b)(1)-(3); 42 CFR 438.236(b)(4)]

4.8.2.2 The MCO shall develop Practice Guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

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4.8.2.3 The MCO shall adopt Practice Guidelines consistent with the standards of care and evidence-based practices of specific professional specialty groups, as identified by DHHS. These include, but are not limited to:

4.8.2.3.1 ASAM, as further described in Section 4.11.6.7 (Substance Use Disorder Clinical Evaluations and Treatment Plans);

4.8.2.3.2 The recommendations of the U.S. Preventive Services Task Force for the provision of primary and secondary care to adults, rated A or B;

4.8.2.3.3 The preventative services recommended by the AAP Bright Futures program; and

4.8.2.3.4 The Zero Suicide Consensus Guide for Emergency Departments²⁰

4.8.2.4 The MCO may substitute generally recognized, accepted guidelines to replace the U.S. Preventive Services Task Force and AAP Bright Futures program requirements, provided that the MCO meets all other Practice Guidelines requirements indicated within this Section 4.8.2 (Practice Guidelines and Standards) of the Agreement and that such substitution is reviewed by DHHS prior to implementation.

4.8.2.5 The MCO shall disseminate Practice Guidelines to DHHS and all affected Providers and make Practice Guidelines available, including but not limited to the MCO's website, and, upon request, to Members and potential Members. [42 CFR 438.236(c)]

4.8.2.6 The MCO's decisions regarding Utilization Management, Member education, and coverage of services shall be consistent with the MCO's clinical Practice Guidelines. [42 CFR 438.236(d)]

4.8.3 Medical Necessity Determination

4.8.3.1 The MCO shall specify what constitutes "Medically Necessary" services in a manner that:

4.8.3.1.1 Is no more restrictive than the NH DHHS FFS Medicaid program including quantitative and non-quantitative treatment limits, as indicated in State laws and regulations, the Medicaid State Plan, and other State policies and procedures [42 CFR 438.210(a)(5)(i)]; and

²⁰ Suicide Prevention Resource Center, "Care for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments"

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4.8.3.1.2 Addresses the extent to which the MCO is responsible for covering services that address [42 CFR 438.210(a)(5)(ii)(A)-(C)]:

4.8.3.1.2.1. The prevention, stabilization, diagnosis, and treatment of a Member's diseases, condition, and/or disorder that results in health impairments and/or disability;

4.8.3.1.2.2. The ability for a Member to achieve age-appropriate growth and development; and

4.8.3.1.2.3. The ability for a Member to attain, maintain, or regain functional capacity.

4.8.3.2 For Members twenty-one (21) years of age and older, "Medically Necessary" shall be as defined in Section 2.1.74.2 (Definitions).

4.8.3.3 For Members under twenty-one (21) years of age, per EPSDT, "Medically Necessary" shall be as defined in Section 2.1.74.1 (Definitions).

4.8.4 Notices of Coverage Determinations

4.8.4.1 The MCO shall provide the requesting Provider and the Member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

4.8.4.2 Urgent Determinations and Continued/Extended Services

4.8.4.2.1 The MCO shall make Utilization Management decisions in a timely manner. The following minimum standards shall apply:

4.8.4.2.1.1. Urgent Determinations: Determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for service for ninety-eight percent (98%) of requests, unless the Member or Member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.8.4.2.1.2. In the case of such failure, the MCO shall notify the Member or Member's representative within twenty-four (24) hours of receipt of the request

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and shall advise the Member or Member's representative of the specific information necessary to make a determination.

4.8.4.2.1.3. The Member or Member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information.

4.8.4.2.1.4. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the MCO's receipt of the specified additional information; or the end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.2.1.5. Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

4.8.4.3 All Other Determinations

4.8.4.3.1 The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed fourteen (14) calendar days for ninety-five percent (95%) of requests after the receipt of a request.

4.8.4.3.2 An extension of up to fourteen (14) calendar days is permissible for non-diagnostic radiology determinations if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

4.8.4.3.3 If an extension is necessary due to a failure of the Member or Member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the Member or Member's representative shall be given at least forty-five (45)

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calendar days from receipt of the notice within which to provide the specified information.

4.8.4.3.4 Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of:

4.8.4.3.4.1. The MCO's receipt of the specified additional information; or

4.8.4.3.4.2. The end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.3.4.3. When the MCO extends the timeframe, the MCO shall give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

4.8.4.3.5 The determination of a post service authorization shall be made within thirty (30) calendar days of the date of filing. In the event the Member fails to provide sufficient information to determine the request, the MCO shall notify the Member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the Member shall be given at least forty-five (45) calendar days to provide the required information.

4.8.4.3.6 The thirty (30) calendar day period for determination shall be tolled until such time as the Member submits the required information.

4.8.4.3.7 Whenever there is an adverse determination, the MCO shall notify the ordering Provider and the Member. For an adverse standard authorization decision, the MCO shall provide written notification within three (3) calendar days of the decision.

4.8.4.3.8 The MCO shall provide Utilization Management data to include but not be limited to timely processing, results, and frequency of service authorizations in accordance with Exhibit O.

4.8.5 Advance Directives

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4.8.5.1 The MCO shall adhere to all State and federal laws pertaining to Advance Directives including, but not limited to, RSA 137-J:21.

4.8.5.2 The MCO shall maintain written policies and procedures that meet requirements for Advance Directives in Subpart I of 42 CFR 489.

4.8.5.3 The MCO shall adhere to the definition of Advance Directives as defined in 42 CFR 489.100.

4.8.5.4 The MCO shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a)]

4.8.5.5 The MCO shall educate staff concerning policies and procedures on Advance Directives. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)]

4.8.5.6 The MCO shall not condition the provision of care or otherwise discriminate against a Member or potential Member based on whether or not the Member has executed an Advance Directive. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3)]

4.8.5.7 The MCO shall provide information in the Member Handbook with respect to how to exercise an Advance Directive, as described in Section 4.4.1.4 (Member Handbook). [42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j)]

4.8.5.8 The MCO shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. [42 CFR 438.3(j)(4)]

4.9 Member Education and Incentives

4.9.1 General Provisions

4.9.1.1 The MCO shall develop and implement evidenced-based wellness and prevention programs for its Members. The MCO shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by DHHS, including the National Diabetes Prevention Program. The MCO shall

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also participate in other public health initiatives at the direction of DHHS.

4.9.1.2 The MCO shall provide Members with general health information and provide services to help Members make informed decisions about their health care needs. The MCO shall encourage Members to take an active role in shared decision-making.

4.9.1.3 The MCO shall promote personal responsibility through the use of incentives and care management. The MCO shall reward Members for activities and behaviors that promote good health, health literacy and Continuity of Care. DHHS shall review and approve all reward activities proposed by the MCO prior to their implementation.

4.9.2 Member Health Education

4.9.2.1 The MCO shall develop and initiate a Member health education program that supports the overall wellness, prevention, and Care Management programs, with the goal of empowering patients to actively participate in their health care.

4.9.2.2 The MCO shall actively engage Members in both wellness program development and in program participation and shall provide additional or alternative outreach to Members who are difficult to engage or who utilize EDs inappropriately.

4.9.3 Member Cost Transparency

4.9.3.1 The MCO shall publish on its website and incorporate in its Care Coordination programs cost transparency information related to the relative cost of Participating Providers for MCO-selected services and procedures, with clear indication of which setting and/or Participating Provider is most cost-effective, referred to as "Preferred Providers."

4.9.3.2 The cost transparency information published by the MCO shall be related to select, non-emergent services, designed to permit Members to select between Participating Providers of equal quality, including the appropriate setting of care as assessed by the MCO. The services for which cost transparency data is provided may include, for example, services conducted in an outpatient hospital and/or ambulatory surgery center. The MCO should also include information regarding the appropriate use of EDs relative to low-acuity, non-emergent visits.

4.9.3.3 The information included on the MCO's website shall be accessible to all Members and also be designed for use specifically

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by Members that participate in the MCO's Reference-Based Pricing Incentive Program, as described in Section 4.9.4 (Member Incentive Programs) below.

4.9.4 Member Incentive Programs

4.9.4.1 The MCO shall develop at least one (1) Member Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as further described within this Section 4.9.4 (Member Incentive Programs) of the Agreement. The MCO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives of the MCOs and Providers described in Section 4.14 (Alternative Payment Models) of this Agreement as appropriate.

4.9.4.2 For all Member Incentive Programs developed, the MCO shall provide to participating Members that meet the criteria of the MCO-designed program cash or other incentives that:

4.9.4.2.1 May include incentives such as gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used for health-related purchases, gym memberships; and

4.9.4.2.2 Do not, in a given fiscal year for any one (1) Member, exceed a total monetary value of two hundred and fifty dollars (\$250.00).

4.9.4.3 The MCO shall submit to DHHS for review and approval all Member Incentive Program plan proposals prior to implementation

4.9.4.4 Within the plan proposal, the MCO shall include adequate assurances, as assessed by DHHS, that:

4.9.4.4.1 The program meets the requirements of 1112(a)(5) of the Social Security Act; and

4.9.4.4.2 The program meets the criteria determined by DHHS as described in Section 4.9.4.6 (Healthy Behavior Incentive Programs) and Section 4.9.4.7 (Reference-Based Pricing Incentive Programs) below.

4.9.4.5 The MCO shall report to DHHS, at least annually, the results of any Member Incentive Programs in effect in the prior twelve (12) months, including the following metrics and those indicated by DHHS, in accordance with Exhibit O:

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4.9.4.5.1 The number of Members in the program's target population, as determined by the MCO;

4.9.4.5.2 The number of Members that received any incentive payments, and the number that received the maximum amount as a result of participation in the program;

4.9.4.5.3 The total value of the incentive payments;

4.9.4.5.4 An analysis of the statistically relevant results of the program; and

4.9.4.5.5 Identification of goals and objectives for the next year informed by the data.

4.9.4.6 Healthy Behavior Incentive Programs

4.9.4.6.1 The MCO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:

4.9.4.6.1.1. Incorporate incentives for Members who complete a Health Risk Assessment Screening, in compliance with Section 4.10.2 of this Agreement (Health Risk Assessment Screening);

4.9.4.6.1.2. Increase the timeliness of prenatal care, particularly for Members at risk of having a child with NAS;

4.9.4.6.1.3. Address obesity;

4.9.4.6.1.4. Prevent diabetes;

4.9.4.6.1.5. Support smoking cessation;

4.9.4.6.1.6. Increase lead screening rates in one- and two-year old Members; and/or

4.9.4.6.1.7. Other similar types of healthy behavior incentive programs in consultation with the Division of Public Health within DHHS and in alignment with the DHHS Quality Strategy and the MCO's QAPI, as described in Section 4.9.3 (Member Cost Transparency).

4.9.4.7 Reference-Based Pricing Incentive Programs

4.9.4.7.1 The MCO shall develop at least one (1) Reference-Based Pricing Member Incentive Program that encourages Members to use, when reasonable, Preferred Providers as assessed and indicated by the MCO and on its website in compliance with the

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Cost Transparency requirements included in Section 4.9.3 (Member Cost Transparency). The Reference-Based Pricing Member Incentive Program shall also include means for encouraging members' appropriate use of EDs and opportunities to direct Members to other settings for low acuity, non-emergent visits.

4.9.4.7.2 The MCO's Reference-Based Pricing Member Incentive Program shall be designed such that the Member may gain and lose incentives (e.g., through the development of a points system that is monitored throughout the year) based on the Member's adherence to the terms of the program throughout the course of the year.

4.9.5 Collaboration with New Hampshire Tobacco Cessation Programs

4.9.5.1 [Amendment #7:] The MCO shall promote and utilize the DHHS-approved tobacco treatment quitline, 1-800-QUITNOW (1-800-784-8669) ~~cessation quitline and tobacco cessation program~~ to provide:

4.9.5.1.1 Intensive tobacco cessation treatment through a DHHS-approved tobacco cessation quitline;

4.9.5.1.2 Individual tobacco cessation coaching/counseling in conjunction with tobacco cessation medication;

4.9.5.1.3 The following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by DHHS; and

4.9.5.1.4 Combination therapy, when available through quitline, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release.

4.9.5.2 The MCO shall provide tobacco cessation treatment to include, at a minimum:

4.9.5.2.1 Tobacco cessation coaching/counseling in addition to the quitline;

4.9.5.2.2 In addition to the quitline, the following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by DHHS;

4.9.5.2.3 In addition to the quitline, Combination therapy, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy

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(gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release;

4.9.5.2.4 Rebateable FDA-approved non-nicotine prescription medications; and

4.9.5.2.5 Rebateable FDA-approved prescription inhalers and nasal sprays.

4.9.5.3 The MCO shall report on tobacco cessation activities in accordance with Exhibit O.

4.10 Care Coordination and Care Management

4.10.1 Care Coordination and Care Management General Requirements

4.10.1.1 The MCO shall be responsible for the management, coordination, and Continuity of Care for all Members, and shall develop and maintain policies and procedures to address this responsibility.

4.10.1.2 The MCO shall implement Care Coordination and Care Management procedures to ensure that each Member has an ongoing source of care appropriate to their needs. [42 CFR 438.208(b)]

4.10.1.3 The MCO shall provide the services described in this Section 4.10 (Care Coordination and Care Management) for all Members who need Care Coordination and Case Management services regardless of their acuity level.

4.10.1.4 [Amendment #2:] The MCO shall either provide these services directly or shall Subcontract with Local Care Management ~~Networks—entities~~ as described in Section 4.10.8 (Local Care Management) to perform Care Coordination and Care Management functions.

4.10.1.5 [Amendment #2:] Care Coordination means the interaction with established local community-based Providers of care including Local Care Management ~~Networks—entities~~ to address the physical, mental and psychosocial needs of the Member.

4.10.1.6 Care Management means direct contact with a Member focused on the provision of various aspects of the Member's physical, mental, Substance Use Disorder status and needed social supports that shall enable the Member in achieving the best health outcomes.

4.10.1.7 The MCO shall implement Care Coordination and Care Management in order to achieve the following goals:

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- 4.10.1.7.1 Improve care of Members;
- 4.10.1.7.2 Improve health outcomes;
- 4.10.1.7.3 Reduce inpatient hospitalizations including readmissions;
- 4.10.1.7.4 Improve Continuity of Care;
- 4.10.1.7.5 Improve transition planning;
- 4.10.1.7.6 Improve medication management;
- 4.10.1.7.7 Reduce utilization of unnecessary Emergency Services;
- 4.10.1.7.8 Reduce unmet resource needs (related to social determinants of health);
- 4.10.1.7.9 Decrease total costs of care; and
- 4.10.1.7.10 Increase Member satisfaction with their health care experience.

4.10.1.8 The MCO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including PCPs, specialists, behavioral health Providers, and social service resources; the process shall include, but not be limited to, the designation of a Care Manager who shall be responsible for leading the coordination of care.

4.10.1.9 The MCO shall implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives from any other MCO. [42 CFR 438.208(b)(2)(ii)]

4.10.1.10 The MCO shall also implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives in FFS Medicaid, including dental services for children under the age of twenty-one (21). [42 CFR 438.208(b)(2)(iii)]

4.10.1.11 [Amendment #9:] The MCO shall provide care coordination support for Members who require services not covered by this Agreement as they may receive services through other appropriate Medicaid, commercial, or government health insurance programs. In such cases, the MCO's responsibility shall include coordination and referrals in compliance with 42 CFR 438.208(b)(2)(iii)-(iv).

4.10.2 Health Risk Assessment Screening

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4.10.2.1 The Health Risk Assessment Screening process shall identify the need for Care Coordination and Care Management services and the need for clinical and non-clinical services including referrals to specialists and community resources.

4.10.2.2 The MCO shall conduct a Health Risk Assessment Screening of all existing and newly enrolled Members within ninety (90) calendar days of the effective date of MCO enrollment to identify Members who may have unmet health care needs and/or Special Health Care Needs [42 CFR 438.208(c)(1)].

4.10.2.3 The MCO is not required to conduct a Health Risk Assessment Screening of Members residing in a nursing facility more than one hundred (100) consecutive calendar days.

4.10.2.4 The Health Risk Assessment shall be the same for each MCO. The agreed upon screening tool developed jointly by the MCOs shall be submitted to DHHS for review and approval, as part of the Readiness Review process, and annually thereafter.

4.10.2.5 The Health Risk Assessment Screening may be conducted by telephone, in person, or through completion of the form in writing by the Member. The MCO shall make at least three (3) reasonable attempts to contact a Member at the phone number most recently reported by the Member. [42 CFR 438.208(b)(3)]

4.10.2.6 Documentation of the three (3) attempts shall be included in the MCO electronic Care Management record. Reasonable attempts shall occur on not less than three (3) different calendar days, at different hours of the day including day and evening hours and after business hours. If after the three (3) attempts are unsuccessful, the MCO shall send a letter to the Member's last reported residential address with the Health Risk Assessment form for completion.

4.10.2.7 [Amendment #8:] [Amendment #2:] The MCO may also Subcontract with a Designated Local Care Management Network Entity, community-based agency or a primary care practice who shall engage the Member to complete the Health Risk Assessment screening either telephonically or in-person either in an agency office/clinic setting, during a scheduled home visit or medical appointment.

4.10.2.8 All completed Health Risk Assessments shall be shared with the Member's assigned PCP for inclusion in the Member's medical record and within seven (7) calendar days of completing the screening.

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4.10.2.9 The MCO shall report the number of Members who received a Health Risk Assessment, in accordance with Exhibit O.

4.10.2.10 The MCO shall share with DHHS and/or other MCOs the results of any identification and assessment of that Member's needs to prevent duplication of activities. [42 CFR 438.208(b)(4)]

4.10.2.11 The MCO shall report to DHHS its performance against Health Risk Assessment requirements, as described in Exhibit O.

4.10.2.12 ~~[Amendment #8:] [Amendment #5:]~~ The MCO shall ensure Member Health Risk Assessment completion for Members shall be completed for at least twenty-five percent (25%) fifty percent (50%) of the plan's total required Members ~~to be considered eligible for a performance based award described in the Performance Based Auto-Assignment Guidance, or the MCO shall provide to DHHS for review and approval additional documentation that describes the MCO's reasoning for failure to successfully complete Health Risk Assessments for fifty percent (50%) of Members. The MCO's reasoning shall be considered by DHHS prior to imposing Liquidated Damages, as described in Section 5.5.2 of this Agreement.~~

4.10.2.13 The evidence-based Health Risk Assessment Screening tool shall identify, at minimum, the following information about Members:

4.10.2.13.1 Demographics;

4.10.2.13.2 Chronic and/or acute conditions;

4.10.2.13.3 Chronic pain;

4.10.2.13.4 The unique needs of children with developmental delays, Special Health Care Needs or involved with the juvenile justice system and child protection agencies (i.e. DCYF);

4.10.2.13.5 Behavioral health needs, including depression or other Substance Use Disorders as described in sections, including but not limited to Section 4.11.1.16 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.11.5.4 (Comprehensive Assessment and Care Plans), and Section 4.11.6.6 (Provision of Substance Use Disorder Services);

4.10.2.13.6 The need for assistance with personal care such as dressing or bathing or home chores and grocery shopping;

4.10.2.13.7 Tobacco Cessation needs;

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4.10.2.13.8 Social determinants of health needs, including housing, childcare, food insecurity, transportation and/or other interpersonal risk factors such as safety concerns/caregiver stress; and

4.10.2.13.9 Other factors or conditions about which the MCO shall need to be aware to arrange available interventions for the Member.

4.10.2.14 Wellness Visits

4.10.2.14.1 For all Members, inclusive of Granite Advantage Members, the MCO shall support the Member to arrange a wellness visit with his or her PCP, either previously identified or selected by the Member from a list of available PCPs.

4.10.2.14.2 The wellness visit shall include appropriate assessments for the purpose of developing a health wellness and care plan:

4.10.2.14.2.1. Both physical and behavioral health, including screening for depression;

4.10.2.14.2.2. Mood, suicidality; and

4.10.2.14.2.3. Substance Use Disorder.

4.10.3 Priority Populations

4.10.3.1 The following populations shall be considered Priority Populations and are most likely to have Care Management needs:

4.10.3.1.1 Adults with Special Health Care Needs, meaning those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age.

4.10.3.1.1.1. This includes, but is not limited to Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis; or with chronic pain;

4.10.3.1.2 Children with Special Health Care Needs meaning those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age.

4.10.3.1.2.1. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with NAS; in high stress

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social environments/caregiver stress; receiving Family Centered Early Supports and Services, or participating in Special Medical Services or Partners in Health Services with an SED, I/DD or Substance Use Disorder diagnosis;

4.10.3.1.3 Members receiving services under HCBS waivers;

4.10.3.1.4 Members identified as those with rising risk. The MCO shall establish criteria that define Members at rising risk for approval by DHHS as part of the Readiness Review process and reviewed and approved annually;

4.10.3.1.5 Individuals with high unmet resources needs meaning MCM Members who are homeless; experiencing domestic violence or perceived lack of personal safety; and/or demonstrate unmet resource needs as further described in Section 4.10.10 (Coordination and Integration with Social Services and Community Care);

4.10.3.1.5.1. Recently incarcerated;

4.10.3.1.5.2. Mothers of babies born with NAS;

4.10.3.1.5.3. Pregnant women with Substance Use Disorders;

4.10.3.1.5.4. IV Drug Users, including Members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use;

4.10.3.1.5.5. Members who have been in the ED for an overdose event in the last twelve (12) months;

4.10.3.1.5.6. Members who have a suicide attempt in the last twelve (12) months;

4.10.3.1.5.7. Members with an I/DD diagnosis; and/or

4.10.3.1.5.8. Other Priority Populations as determined by the MCO and/or by DHHS.

4.10.4 Risk Scoring and Stratification

4.10.4.1 The MCO shall use a Risk Scoring and Stratification methodology to identify Members who are part of a Priority Population or who are otherwise high risk/high need for Care Management and who should receive a Comprehensive Assessment.

4.10.4.2 The MCO shall provide protocols to DHHS for review and approval on how Members are stratified by severity and risk level,

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including details regarding the algorithm and data sources used to identify Members eligible for Care Management.

4.10.4.3 Such protocols shall be submitted as part of the Readiness Review process and annually thereafter.

4.10.4.4 Risk Scoring and Stratification of Members should be conducted at MCO program roll out and monthly thereafter.

4.10.4.5 The MCO's Risk Scoring and Stratification methodology shall take into account, at a minimum, the following information:

4.10.4.5.1 Results of the health risk assessment screening;

4.10.4.5.2 Claims history and Encounter Data;

4.10.4.5.3 Pharmacy data;

4.10.4.5.4 Immunizations;

4.10.4.5.5 ADT of Members to and from inpatient facilities;

4.10.4.5.6 Provider referral;

4.10.4.5.7 Member self-referral;

4.10.4.5.8 Hospital stays of more than two (2) weeks;

4.10.4.5.9 Members without secure and stable housing post hospital discharge;

4.10.4.5.10 Three (3) or more ED visits within a single calendar quarter;

4.10.4.5.11 Discharge from inpatient Behavioral Health Services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center; and

4.10.4.5.12 Neonatal Intensive Care Unit discharges.

4.10.4.6 The MCO shall document and submit to DHHS for review and approval the details of its Risk Scoring and Stratification methodology as part of its Readiness Review and annually thereafter. This submission shall include:

4.10.4.6.1 Information and data to be utilized;

4.10.4.6.2 Description of the methodology;

4.10.4.6.3 Methodology and Criteria for identifying high risk/high need Members in addition to those who are in Priority Populations;

4.10.4.6.4 Number of risk strata;

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4.10.4.6.5 Criteria for each risk stratum, including but not limited to high risk/high need members in need of Care Management; and

4.10.4.6.6 Approximate expected population in each stratum.

4.10.4.7 The MCO shall submit any change in its risk stratification methodologies, to include any additions or deletions to that methodology, for DHHS review ninety (90) calendar days prior to the change being implemented.

4.10.4.8 The MCO shall report annually the number and percentage of Members who are identified in each of the risk strata in accordance with Exhibit O.

4.10.5 Comprehensive Assessment for High-Risk and High-Need Members

4.10.5.1 The MCO and its Subcontractors shall implement mechanisms to conduct a Comprehensive Assessment for each Medicaid Member in order to identify whether they have Special Health Care Needs and any on-going special conditions that require a course of treatment or regular care monitoring. [42 CFR 438.208(c)(2)]

4.10.5.2 The MCO shall identify Members who may require a Comprehensive Assessment for Care Management through multiple sources to include but not be limited to:

4.10.5.2.1 Health risk assessment screenings;

4.10.5.2.2 Risk Scoring and Stratification;

4.10.5.2.3 Claims/encounter analysis;

4.10.5.2.4 Provider referrals;

4.10.5.2.5 Member/caregiver self-referral; and

4.10.5.2.6 Referrals from community based medical, mental health, Substance Use Disorder Providers, or social service entities.

4.10.5.3 The Comprehensive Assessment shall identify a Member's health condition that requires a course of treatment that is either episodic, which is limited in duration or significance to a particular medical episode,

or requires ongoing Care Management monitoring to ensure the Member is managing his or her medical and/or behavioral health care needs (including screening for depression, mood, suicidality, and Substance Use Disorder).

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4.10.5.4 The Comprehensive Assessment shall be a person-centered assessment of a Member's medical and behavioral care needs, functional status, accessibility needs, strengths and supports, health care goals and other characteristics that shall inform whether the Member should receive Care Management and shall inform the Member's ongoing care plan and treatment. The MCO shall incorporate into the Comprehensive Assessment information obtained as a result of Provider referral, the wellness visit and/or otherwise.

4.10.5.5 The MCO's Comprehensive Assessment tool shall be submitted for DHHS review and approval as part of the Readiness Review process and annually thereafter.

4.10.5.6 The MCO shall make best efforts to complete the Comprehensive Assessment within thirty (30) calendar days of identifying a Member as being part of one or more Priority Populations, identified through Risk Scoring and Stratification or having received a referral for Care Management.

4.10.5.7 The MCO shall not withhold any Medically Necessary Services including EPSDT services per Section 4.1.8 (Early and Periodic Screening, Diagnostic, and Treatment) for Members while awaiting the completion of the Comprehensive Assessment but may conduct utilization review for any services requiring Prior Authorization.

4.10.5.8 The MCO shall conduct the Comprehensive Assessment in a location of the Member's choosing and shall endeavor to conduct the Comprehensive Assessment in-person for populations where the quality of information may be compromised if provided telephonically (e.g., for Members whose physical or behavioral health needs may impede the ability to provide comprehensive information by telephone), including others in the person's life in the assessment process such as family members, paid and natural supports as agreed upon and appropriate to the Member/Member's parents to the maximum extent practicable.

4.10.5.9 Additionally, participation in the Comprehensive Assessment shall be extended to the Member's local community care team or Case Management staff, including but not limited to Area Agencies, CFI waiver, CMH Programs and Special Medical Services 1915(i) Care Management Entities/case managers as practicable.

4.10.5.10 The MCO shall develop and implement a Comprehensive Assessment tailored to Members that include, at a minimum, the following domains/content:

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- 4.10.5.10.1 Members' immediate care needs;
 - 4.10.5.10.2 Demographics;
 - 4.10.5.10.3 Education;
 - 4.10.5.10.4 Housing;
 - 4.10.5.10.5 Employment and entitlements;
 - 4.10.5.10.6 Legal involvement;
 - 4.10.5.10.7 Risk assessment, including suicide risk;
 - 4.10.5.10.8 Other State or local community and family support services currently used;
 - 4.10.5.10.9 Medical and other health conditions;
 - 4.10.5.10.10 Physical, I/DDs;
 - 4.10.5.10.11 Functional status (activities of daily living (ADL)/instrumental activities of daily living (IADL)) including cognitive functioning;
 - 4.10.5.10.12 Medications;
 - 4.10.5.10.13 Available informal, caregiver, or social supports, including peer supports;
 - 4.10.5.10.14 Current and past mental health and substance use status and/or disorders;
 - 4.10.5.10.15 Social determinants of health needs; and
 - 4.10.5.10.16 Exposure to adverse childhood experiences or other trauma (e.g., parents with mental health or Substance Use Disorders that affect their ability to protect the safety of the child, child abuse or neglect).
- 4.10.5.11 The MCO shall provide to DHHS a copy of the Comprehensive Assessment Form and all policies and procedures relating to conducting the Comprehensive Assessment for DHHS review as part of the Readiness Review process and annually thereafter.
- 4.10.5.12 The MCO shall conduct a re-assessment of the Comprehensive Assessment for a Member receiving ongoing care management:
- 4.10.5.12.1 At least annually;
 - 4.10.5.12.2 When the Member's circumstances or needs change significantly;

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4.10.5.12.3 At the Member's request; and/or

4.10.5.12.4 Upon DHHS's request.

4.10.5.13 The MCO shall share the results of the Comprehensive Assessment in writing with the Member's local community based care team within fourteen (14) calendar days to inform care planning and treatment planning, with Member consent to the extent required by State and federal law.

4.10.5.14 The MCO shall report to DHHS the following in accordance with Exhibit O:

4.10.5.14.1 Assessments conducted as a percentage (%) of total Members and by Priority Population category;

4.10.5.14.2 Assessments completed by a Subcontractor entity, such as but not limited to IDNs, CMH Programs, Special Medical Services, HCBS case managers, and Area Agencies;

4.10.5.14.3 Timeliness of assessments;

4.10.5.14.4 Timeliness of dissemination of assessment results to PCPs, specialists, behavioral health Providers and other members of the local community based care team; and

4.10.5.14.5 Quarterly report of unmet resource needs, aggregated by county, based on the care screening and Comprehensive Assessment tool to include number of Members reporting in accordance with Exhibit O.

4.10.6 Care Management for High Risk and High Need Members

4.10.6.1 The MCO shall provide Care Management for Members identified as "high-risk"/"high-need" through the Comprehensive Assessment. Every high-risk/high-need Member identified as needing Care Management shall be assigned a designated Care Manager.

4.10.6.2 [Amendment #5:] Beginning January 1, 2021, Care Management for high-risk/high-need Members shall be conducted for at least three percent (3%) of the total Members. [Amendment #5:] For the period January 1, 2021 through June 30, 2021, Care Management for high-risk/high-need Members shall be conducted for at least three percent (3%) of the total Members by March 1, 2021.

4.10.6.2.1 [Amendment #6:] Beginning March 1, 2021, Care Management for shall be conducted for at least three percent (3%) of the total membership.

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~~[Amendment #1:] Care Management for high-risk/high-need Members shall be conducted for at least 15 percent (15%) of the total Members by March 1, 2020, or the MCO shall provide to DHHS documentation of how fewer Members were determined not to meet the MCO's Risk Stratification Criteria for being high-risk/high-need members in need of Care Management.~~

~~[Base Contract:] Care Management for high-risk/high-need Members shall be conducted for at least 15 percent (15%) of the total Members by January 1, 2020, or the MCO shall provide to DHHS documentation of how fewer Members were determined not to meet the MCO's Risk Stratification Criteria for being high-risk/high-need members in need of Care Management.~~

4.10.6.3 Members selected for Care Management shall be informed of:

4.10.6.3.1 The nature of the Care Management engagement relationship;

4.10.6.3.2 Circumstances under which information shall be disclosed to third parties, consistent with State and federal law;

4.10.6.3.3 The availability of a grievance and appeals process;

4.10.6.3.4 The rationale for implementing Care Management services; and

4.10.6.3.5 The processes for opting out of and terminating Care Management services.

4.10.6.4 The MCO's Care Management responsibilities shall include, at a minimum:

4.10.6.4.1 Coordination of physical, mental health, Substance Use Disorder and social services;

4.10.6.4.2 Quarterly medication reconciliation;

4.10.6.4.3 Monthly telephonic contact with the Member;

4.10.6.4.4 Monthly communication with the care team either in writing or telephonically for coordination and updating of the care plan for dissemination to care team participants;

4.10.6.4.5 Referral follow-up monthly;

4.10.6.4.6 Peer support;

4.10.6.4.7 Support for unmet resource needs;

4.10.6.4.8 Training on disease self-management, as relevant; and

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4.10.6.4.9 Transitional Care Management as defined in Section 4.10.9 (Transitional Care Management).

4.10.6.5 The MCO shall convene a local community based care team for each Member receiving Care Management where relevant, dependent on a Member's needs including, but not limited to, the Member, caretaker(s), PCP, behavioral health Provider(s), specialist(s), HCBS case managers, school personnel as needed, nutritionist(s), and/or pharmacist(s).

4.10.6.6 The care team shall be chosen by the Member whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships.

4.10.6.7 The MCO shall identify what information is to be shared and how that information is communicated among all of the care team participants concerned with a Member's care to achieve safer and more effective health care including how the Care Coordination program interfaces with the Member's PCP and/or specialist Providers and existing community resources and supports.

4.10.6.8 The MCO shall develop a care plan, within 30 calendar days of the completed Comprehensive Assessment, for each high-risk/high need Member identified through a Comprehensive Assessment who is in need of a course of treatment or regular Care Management monitoring. [42 CFR 438.208(c)(3)]

4.10.6.9 The MCO's care plan shall be regularly updated and incorporate input from the local community based care team participants and the Member. The care plan shall be comprehensively updated:

4.10.6.9.1 At least quarterly;

4.10.6.9.2 When a Member's circumstances or needs change significantly;

4.10.6.9.3 At the Member's request;

4.10.6.9.4 When a re-assessment occurs; and

4.10.6.9.5 Upon DHHS's request.

4.10.6.10 The care plan format shall be submitted to DHHS for review as part of the Readiness Review process and annually thereafter.

4.10.6.11 The MCO shall track the Member's progress through routine care team conferences, the frequency to be determined by the MCO based on the Member's level of need.

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4.10.6.12 The MCO shall develop policies and procedures that describe when Members should be discharged from the Care Management program, should the care team determine that the Member no longer requires a course of treatment which was episodic or no longer needs ongoing care monitoring.

4.10.6.13 Policies and procedures for discharge shall include a Member notification process.

4.10.6.14 For high-risk/high-needs Members who have been determined, through a Comprehensive Assessment, to need a course of treatment or regular care monitoring, the MCO shall ensure there is a mechanism in place to permit such Members to directly access a specialist as appropriate for the Member's condition and identified needs. [42 CFR 438.208(c)(4)]

4.10.6.15 The MCO shall ensure that each Provider furnishing services to Members maintains and shares a Member health record in accordance with professional standards. [42 CFR 438.208(b)(5)]

4.10.6.16 The MCO shall use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Member in accordance with confidentiality requirements in 45 CFR 160 and 164, this Agreement, and all other applicable laws and regulations. [42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164]

4.10.6.17 The MCO shall develop and implement a strategy to address how the Interoperability Standards Advisory standards, from the Office of the National Coordinator for Health Information Technology, informs the MCO system development and interoperability.

4.10.7 Care Managers

4.10.7.1 The MCO shall formally designate a Care Manager that is primarily responsible for coordinating services accessed by the Member.

4.10.7.2 The MCO shall provide to Members information on how to contact their designated Care Manager. [42 CFR 438.208(b)(1)]

4.10.7.3 [Amendment #2:] Care Managers, whether hired by the MCO or subcontracted through a Designated Local Care Management Network-Entity, shall have the qualifications and competency in the following areas:

4.10.7.3.1 All aspects of person-centered needs assessments and care planning;

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- 4.10.7.3.2 Motivational interviewing and self-management;
- 4.10.7.3.3 Trauma-informed care;
- 4.10.7.3.4 Cultural and linguistic competency;
- 4.10.7.3.5 Understanding and addressing unmet resource needs including expertise in identifying, accessing and utilizing available social support and resources in the Member's community; and
- 4.10.7.3.6 Adverse childhood experiences and trauma.
- 4.10.7.4 Care Managers shall be trained in the following:
 - 4.10.7.4.1 Disease self-management;
 - 4.10.7.4.2 Person-centered needs assessment and care planning including coordination of care needs;
 - 4.10.7.4.3 Integrated and coordinated physical and behavioral health;
 - 4.10.7.4.4 Behavioral health crisis response (for Care Managers with assigned Members with behavioral health needs);
 - 4.10.7.4.5 Cultural and linguistic competency;
 - 4.10.7.4.6 Family support; and
 - 4.10.7.4.7 Understanding and addressing unmet resource needs, including expertise in identifying and utilizing available social supports and resources in the Member's community.
- 4.10.7.5 Care Managers shall remain conflict-free which shall be defined as not being related by blood or marriage to a Member, financially responsible for a Member, or with any legal power to make financial or health related decisions for a Member.

4.10.8 Local Care Management

4.10.8.1 Local Care Management shall mean that the MCO shall provide real-time, high-touch, in-person Care Management and consistent follow up with Providers and Members to assure that selected Members are making progress with their care plans.

4.10.8.1.1 [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] As described in this Section 4.10.8, Local Care Management is optional for the period January 1, 2021 through August 31, 2024 ~~June 30, 2023 2021.~~

4.10.8.1.1.1. [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] For the period July

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1, 2021 through August 31, 2024 June 30 December 31, 2023, the term "Local Care Management" shall also mean "Care Management" in this Section 4.10.8.

4.10.8.1.2 [Amendment #9] [Amendment #7] [Amendment #6:] Intentionally left blank. The MCO shall be eligible for credit to the withhold calculation described in the MCM Withhold and Incentive Program guidance when the MCO opts to participate in a Department approved Local Care Management Pilot during the period described in Section 4.10.8.1.1, and meets obligations of the Pilot as described in separate guidance. [Amendment #5:] The MCO shall be eligible for a one half percent (.5%) credit to the withhold calculation described in the MCM Withhold and Incentive Program guidance when the MCO opts to participate in a Department approved Local Care Management Pilot during the period described in Section 4.10.8.1.1. Eligibility for the withhold credit requires the MCO's earnest participation and effort to successfully develop the Pilot as determined solely by DHHS and outlined in the MCM Withhold and Incentive Guidance.

4.10.8.1.2.1. [Amendment #6:] For the Pilot timeframe January 1, 2021 through June 30, 2021, the MCO shall be eligible for one-half (.5%) percent credit to the withhold calculation as described in the MCM Withhold and Incentive Guidance.

4.10.8.1.2.2. [Amendment #7:] For the Pilot timeframe July 1, 2021 through December 31, 2021, the MCO shall be eligible for additional one-quarter (.25%) percent credits to the SFY 2021 withhold calculation for successful implementation of each of the four (4) subsequent phases of the Pilot up to a one percent (1%) withhold credit as determined at DHHS's sole discretion. [Amendment #6:] For the Pilot timeframe beginning July 1, 2021, the MCO shall be eligible for additional one-quarter (.25%) percent credits to the withhold calculation for successful implementation of each of the four (4) subsequent phases of the Pilot up to a one percent (1%) withhold credit as described in the MCM Withhold and Incentive Guidance to be developed over time.

4.10.8.1.2.3. [Amendment #6:] Eligibility for the withhold credit requires the MCO's earnest participation and effort to successfully develop the Pilot as determined solely by DHHS and outlined in the MCM Withhold and Incentive Guidance.

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4.10.8.1.3 [Amendment #8:] [Amendment #7:] For the Pilot timeframe January 1, 2022 through ~~June 30~~ December 31, 2022, the MCO shall be eligible for a SFY 2022 withhold calculation credit up to one-half percent (.5%) as described in the MCM Withhold and Incentive Guidance.

4.10.8.1.4 [Amendment #9:]~~[Amendment #8]~~ Intentionally left blank. ~~The MCO shall be eligible for a SFY 2023 withhold capitation credit up to one-half percent (.5%) based on Members who have completed their determinations between July 1, 2022 through December 31, 2022 as described in the MCM Withhold and Incentive Guidance.~~

4.10.8.2 The MCO shall design an effective Local Care Management structure for fifty percent (50%) of high-risk or high-need Members, including those who are medically and socially complex or high utilizers.

4.10.8.3 [Amendment #5:] The MCO shall ensure that the fifty percent (50%) requirement is met by ensuring access to Local Care Management in all regions of New Hampshire by ~~January 1, 2024~~; the MCO shall be considered out of compliance should any one (1) region have less than twenty five percent (25%) of high-risk or high-need Members receiving Local Care Management, unless the MCO receives DHHS approval as part of the MCO's Local Care Management Plan (further described in this Section 4.10.8).

4.10.8.4 The MCO is encouraged to leverage Local Care Management by contracting with designated community-based agencies or Care Management entities, inclusive of IDNs that meet requirements, that shall assume responsibility for performing Care Coordination, Transitional Care Management, and/or Care Management functions for high risk and/or high-need Members.

4.10.8.4.1 [Amendment #2:] After good faith negotiations with a Local Care Management Network Agency should the MCO be unable to contract with the Local Care Management Network Agency for Care Coordination, Transitional Care Management, and/or Care management functions for high-risk/high-need Members, and continue to be unable to contract with any Local Care Management Network Agency after subsequent good faith negotiations with the assistance of DHHS, the MCO may submit to DHHS for a request for an exception to the requirement for compliance with the 50% Local Care Management standard. DHHS may approve or deny the request in its sole discretion.

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4.10.8.5 [Amendment #2:] The MCO, or its Designated Local Care Management Network-Entity, shall designate Care Managers who shall provide in-person Care Management for Members either in the community setting, provider outpatient setting, hospital, or ED.

4.10.8.6 [Amendment #2:] The MCO shall ensure there is a clear delineation of roles and responsibilities between the MCO and Designated Local Care Management Networks-Entities that are responsible for Care Management in order to ensure no gaps or duplication in services.

4.10.8.7 The MCO or its designated Local Care Managers shall be embedded in one (1) outpatient service site, float between multiple outpatient sites, provide transition of care services from the hospital or ED setting, and provide home based Care Management.

4.10.8.8 [Amendment #2:] Designated Local Care Management Networks-Entities shall include:

4.10.8.8.1 [Amendment #2:] IDNs that have been certified as Local Care Management Networks-Entities by DHHS;

4.10.8.8.2 Health Homes, if DHHS elects to implement Health Homes under Medicaid State Plan Amendment authority;

4.10.8.8.3 Designated community-based agencies or Care Management entities, inclusive of IDNs that meet requirements and DHHS designated regional substance use disorder hubs or spokes, that shall assume responsibility for performing Care Coordination, Transitional Care Management, and/or Care Management functions for high risk and/or high-need Members;

4.10.8.8.4 Other contracted entities capable of performing Local Care Management for a designated cohort of Members, as identified by the MCO as part of its Local Care Management Plan (further described in this Section 4.10.8) and approved by DHHS;

4.10.8.8.5 [Amendment #2:] For the delegation to community-based agencies or Care Management entities ~~designated local care management entities~~ not certified by DHHS for medical utilization review services, the MCO shall seek, where required, licensing in accordance with any State or federal law, including but not limited to RSA 420-E, or additional NCQA accreditation.

4.10.8.9 DHHS shall evaluate whether IDNs are able to provide effective Local Care Management services to selected populations; if and when one (1) or more IDNs are certified, the MCO is required to

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directly contract with the certified IDN(s) for the delivery of Local Care Management services.

4.10.8.10 For any IDN that is not certified by DHHS, the MCO is not required to directly contract with the uncertified IDN for the delivery of Local Care Management services (either because the individual IDN was not certified and/or DHHS has not yet instituted its certification process).

4.10.8.10.1 In this instance the MCO shall enter into a memorandum of understanding with the non-certified IDN(s).

4.10.8.10.2 The memorandum of understanding shall identify roles and responsibilities with respect to Members served by the MCO and the IDN(s), and provide for the timely exchange of data between the MCO and the IDN(s) on such Members.

4.10.8.11 The MCO shall also work with IDNs to leverage regional access point services. The MCO is required to contract with and enter into a payment arrangement with qualified IDNs, providing for reimbursement on terms specified by DHHS in guidance unless otherwise approved by DHHS.

4.10.8.12 [Amendment #2:] Any Care Coordination and Care Management requirements that apply to the MCO shall also apply to the MCOs' Designated Local Care Management Networks-Entities.

4.10.8.13 [Amendment #5:] The MCO shall amend its Care Management Plan to describe its Local Care Management Plan by ~~September 1, 2020, as prescribed by DHHS, and annually thereafter in accordance with Exhibit O for prior approval by DHHS;~~ [Amendment #2:] ~~The MCO shall submit to DHHS its Local Care Management Plan in accordance with Exhibit O for prior approval by DHHS as part of the Readiness Review and annually thereafter.~~

4.10.8.14 [Amendment #2:] The Plan shall include the structure of the Local Care Management to be provided, the percentage (%) of high-risk/high-need Members who shall receive Local Care Management, the list of Designated Local Care Management Networks-Entities that shall conduct the Local Care Management, and a description of the geography and Priority Populations the Designated Local Care Management Networks-Entities shall serve.

4.10.8.15 The MCO shall report against their Local Care Management Plans in accordance with Exhibit O, including:

4.10.8.15.1 Volume of Care Management outreach attempts;

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4.10.8.15.2 Number of Members receiving Local Care Management by intensity of engagement;

4.10.8.15.3 Duration of sustained Local Care Management activities;

4.10.8.15.4 Number and percent (%) of Members receiving face-to-face Care Management; and

4.10.8.15.5 Type of staff conducting face-to-face Local Care Management

4.10.8.16 [Amendment #2:] Data Sharing with Local Care Management Networks—Entities

4.10.8.16.1 [Amendment #2:] Consistent with all applicable State and federal laws and regulations, and utilizing all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information and to facilitate the provision of services and Care Management as intended by this Agreement, the MCO shall provide identifiable Member-level data on a monthly basis to Local Care Management Networks—Entities, all community-based agencies or Care Management entities with which the MCO otherwise subcontracts for purposes of providing Care Management and care coordination to MCM Members, and IDNs regarding:

4.10.8.16.1.1. Each Member's diagnosis(es);

4.10.8.16.1.2. Utilization of services;

4.10.8.16.1.3. Total cost of care

4.10.8.16.1.4. Point of access to service.

4.10.8.16.2 [Amendment #8:] The MCO shall, as described in Section 4.10.9 (Transitional Care Management), demonstrate that it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real time or designated receiving facility in real time or near real time.

4.10.8.16.3 [Amendment #2:] The MCO shall ensure that ADT data from applicable hospitals be made available to Primary Care Providers, behavioral health Providers, Integrated Delivery Networks, Local Care Management Networks—Entities, community-based agencies, and all other Care Management entities within twelve (12) hours of the admission, discharge, or transfer.

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4.10.8.16.4 [Amendment #2:] The MCO shall, as directed by DHHS and demonstrated during the readiness period, collaborate with the IDNs to utilize the event notification and shared care plan system employed by IDNs as applicable for exchanging Member information necessary to provide Care Management and Care Coordination services to Members served by an IDN and, as applicable, other Local Care Management Networks-Entities.

4.10.9 Transitional Care Management

4.10.9.1 [Amendment #8:] The MCO shall be responsible for managing transitions of care for all Members moving from one (1) clinical setting to another, including step-up or step-down treatment programs for Members in need of continued mental health and Substance Use Disorder services, to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

4.10.9.2 The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

4.10.9.3 The MCO shall develop policies and procedures for DHHS review, as part of the Readiness Review process and annually thereafter, which describe how transitions of care between settings shall be effectively managed including data systems that trigger notification that a Member is in transition.

4.10.9.4 The MCO's transition of care policies shall be consistent with federal requirements that meet the State's transition of care requirements. [42 CFR 438.62(b)(1)-(2)]

4.10.9.5 The MCO shall have a documented process to, at a minimum:

4.10.9.5.1 Coordinate appropriate follow-up services from any inpatient or facility stay;

4.10.9.5.2 Support continuity of care for Members when they move from home to foster care placement; foster care to independent living; return from foster care placement to community; or change in legal status from foster care to adoption.

4.10.9.5.3 Schedule a face-to-face visit to complete a Comprehensive Assessment and update a Member's care plan when a Member is hospitalized;

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4.10.9.5.4 Evaluate Members for continued mental health and Substance Use Disorder services upon discharge from an inpatient psychiatric facility or residential treatment center as described in Section 4.11.5.18 (New Hampshire Hospital); and

4.10.9.5.5 Coordinate with inpatient discharge planners for Members referred for subacute treatment in a nursing facility.

4.10.9.6 The MCO shall have an established process to work with Providers (including hospitals regarding notice of admission and discharge) to ensure appropriate communication among Providers and between Providers and the MCO to ensure that Members receive appropriate follow-up care and are in the most integrated and cost-effective delivery setting appropriate for their needs.

4.10.9.7 The MCO shall implement a protocol to identify Members who use ED services inappropriately, analyze reasons why each Member did so and provide additional services to assist the Member to access appropriate levels of care including assistance with scheduling and attending follow-up care with PCPs and/or appropriate specialists to improve Continuity of Care, resolve Provider access issues, and establish a medical home.

4.10.9.8 The MCO shall demonstrate, at a minimum, that it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real time or near real time.

4.10.9.9 [Amendment #2:] The MCO shall ensure that ADT data from applicable hospitals be made available to Primary Care Providers, behavioral health Providers, Integrated Delivery Networks, Local Care Management ~~Networks~~ Entities, and all other Care Management Entities within twelve (12) hours of the admission, discharge, or transfer.

4.10.9.10 The MCO shall ensure that Transitional Care Management includes, at a minimum:

4.10.9.10.1 Care Management or other services to ensure the Member's care plan continues;

4.10.9.10.2 Facilitating clinical hand-offs;

4.10.9.10.3 Obtaining a copy of the discharge plan/summary prior to the day of discharge, if available, otherwise, as soon as it is available, and documenting that a follow-up outpatient visit is scheduled, ideally before discharge;

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4.10.9.10.4 Communicating with the Member's PCP about discharge plans and any changes to the care plan;

4.10.9.10.5 Conducting medication reconciliation within forty-eight (48) business hours of discharge;

4.10.9.10.6 Ensuring that a Care Manager is assigned to manage the transition;

4.10.9.10.7 Follow-up by the assigned Care Manager within forty-eight (48) business hours of discharge of the Member;

4.10.9.10.8 Determining when a follow up visit should be conducted in a Member's home

4.10.9.10.9 Supporting Members to keep outpatient appointments; and

4.10.9.10.10 A process to assist with supporting continuity of care for the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care who become enrolled in the plan, including prospective enrollment so that any care required prior to effective date of enrollment is covered.

4.10.9.11 The MCO shall assist with coordination between the children and adolescent service delivery system as these Members transition into the adult mental health service delivery system, through activities such as communicating treatment plans and exchange of information.

4.10.9.12 The MCO shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

4.10.9.12.1 The outpatient Provider shall be involved in the admissions process when possible; if the outpatient Provider is not involved, the outpatient Provider shall be notified promptly of the Member's hospital admission;

4.10.9.12.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan (i.e. an outpatient visit shall be scheduled before discharge to ensure access to proper Provider/medication follow-up; and an appropriate placement or housing site shall be secured prior to discharge);

4.10.9.12.3 The hospital's evaluation shall be performed prior to discharge to determine what, if any, mental health or Substance Use Disorder services are Medically Necessary. Once deemed Medically

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Necessary, the outpatient Provider shall be involved in the discharge planning, the evaluation shall include an assessment for any social services needs such as housing and other necessary supports the young adults need to assist in their stability in their community; and

4.10.9.12.4 A procedure to ensure Continuity of Care regarding medication shall be developed and implemented.

4.10.10 Coordination and Integration with Social Services and Community Care

4.10.10.1- The MCO shall implement procedures to coordinate services the MCO furnishes to Members with the services the Member receives from community and social service Providers. [42 CFR 438.208(b)(2)(iv)]

4.10.10.2 The MCO shall utilize 2-1-1 NH, which is New Hampshire's statewide, comprehensive, information and referral service. The MCO shall leverage and partner with 2-1-1 NH to ensure warm transfers and the ability to report on closed loop referrals.

4.10.10.3 The MCO's Care Management shall include help for Members in addressing unmet resource needs through strategies including, at a minimum:

4.10.10.3.1 How the MCO identifies available community support services and facilitates referrals to those entities for Members with identified needs;

4.10.10.3.2 Providing in-person assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications;

4.10.10.3.3 Having a housing specialist on staff or on contract who can assist Members who are homeless in securing housing; and

4.10.10.3.4 Providing access to medical-legal partnership for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance Providers.

4.10.10.4 In addressing unmet resource needs for Members, the MCO shall promote access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support. The MCO shall establish Care Management competencies, as outlined below:

4.10.10.4.1 Health Risk Assessment Screening, Claims Analysis, and/or Member or Provider Referral: the MCO ensure that a care needs screening, including social determinants of health questions, is conducted.

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4.10.10.4.2 Risk Scoring and Stratification by Member Level of Need: The MCO shall identify Priority Populations for further review and likely receipt of intensive Care Management services. With respect to social determinants, the MCO, at minimum, shall ensure that Priority Populations are inclusive of homeless Members, Members facing multiple barriers to food, housing and transportation.

4.10.10.4.3 High Risk/High-Need Members: The MCO shall ensure that a more in-depth assessment is conducted to confirm the need for Care Management services and begin to develop a care plan. As with the screening, the in-depth assessment shall include questions regarding social determinants of health.

4.10.10.4.4 The MCO shall provide/arrange for Care Management services that take into account social determinants of health. At minimum, these services shall include in-person assistance connecting with social services that can improve health, including a housing specialist familiar with options in the community.

4.10.10.5 For Members who do not require such intensive services, the MCO shall provide guidance/navigational coordination, which includes:

4.10.10.5.1 Ensuring that each Member has an ongoing source of care and health services appropriate for his or her needs;

4.10.10.5.2 Coordinating services provided by community and social support Providers;

4.10.10.5.3 Linking Members to community resources and social supports; and

4.10.10.5.4 Reporting on closed loop referrals or the overall effectiveness of the types of social determinant-related Care Coordination services, in accordance with Exhibit O.

4.10.10.6 The MCO shall develop relationships that actively link Members with other State, local, and community programs that may provide or assist with related health and social services to Members including, but not limited to:

4.10.10.6.1 Juvenile Justice and Adult Community Corrections;

4.10.10.6.2 Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

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4.10.10.6.3 Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

4.10.10.6.4 Public Health Agencies;

4.10.10.6.5 Schools;

4.10.10.6.6 The court system;

4.10.10.6.7 ServiceLink Resource Network;

4.10.10.6.8 2-1-1 NH;

4.10.10.6.9 Housing; and

4.10.10.6.10 VA Hospital and other programs and agencies serving service Members, veterans and their families.

4.10.10.7 The MCO shall report on the number of referrals for social services and community care provided to Members by Member type, consistent with the format and content requirements in accordance with Exhibit O.

4.11 Behavioral Health

4.11.1 **General Coordination Requirements**

4.11.1.1 This section describes the delivery and coordination of Behavioral Health Services and supports, for both mental health and Substance Use Disorder, delivered to children, youth and transition-aged youth/young adults, and adults.

4.11.1.2 The MCO shall deliver services in a manner that is both clinically and developmentally appropriate and that considers the Members, parents, caregivers and other networks of support the Member may rely upon.

4.11.1.3 The delivery of service shall be Member-centered and align with the principles of system of care and Recovery and resiliency.

4.11.1.4 The MCO shall provide Behavioral Health Services in accordance with this Agreement and all applicable State and federal laws and regulations.

4.11.1.5 The MCO shall be responsible for providing a full continuum of physical health and Behavioral Health Services; ensuring continuity and coordination between covered physical health and Behavioral Health Services; and requiring collaboration between physical health and behavioral health Providers.

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4.11.1.6 Consistent with He-M 425, the MCO shall be required to enter into a capitation model of contracting with CMH Programs and CMH Providers, which is essential to supporting the State's Delivery System Reform Incentive Payment Program (DSRIP) waiver and furthering physical and behavioral health integration in the MCM program.

4.11.1.7 The MCO shall comply with key administrative functions and processes, which may include, but are not limited to:

4.11.1.7.1 Processing timely prospective payment from a Member eligibility list provided by the CMH Program/CMH Provider;

4.11.1.7.2 Determining whether Members are eligible for the DHHS-required Capitation Payments, or should be paid on a FFS basis to the CMH Program/CMH Provider;

4.11.1.7.3 Providing detailed MCO data submissions to DHHS and the CMH Program or CMH Provider for purposes of reconciling payments and performance (e.g., 835 file);

4.11.1.7.4 Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs/CMH Providers (by region); and

4.11.1.7.5 All additional capabilities set forth by DHHS during the Readiness Review process.

4.11.1.8 Behavioral Health Subcontracts

4.11.1.8.1 If the MCO enters into a Subcontractor relationship with a behavioral health (mental health or Substance Use Disorder) Subcontractor to provide or manage Behavioral Health Services, the MCO shall provide a copy of the agreement between the MCO and the Subcontractor to DHHS for review and approval, including but not limited to any agreements with CMH Programs and CMH Providers as required in Section 4.11.5.1 (Contracting for Community Mental Health Services).

4.11.1.8.2 Such subcontracts shall address the coordination of services provided to Members by the Subcontractor, as well as the approach to Prior Authorization, claims payment, claims resolution, contract disputes, performance metrics, quality health outcomes, performance incentives, and reporting.

4.11.1.8.3 The MCO remains responsible for ensuring that all requirements of this Agreement are met, including requirements to ensure continuity and coordination between physical health and Behavioral Health Services, and that any Subcontractor adheres to

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all requirements and guidelines, as outlined in Section 3.14 (Subcontractors).

4.11.1.9 Promotion of Integrated Care

4.11.1.9.1 The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible.

4.11.1.9.2 In accordance with Exhibit O, the MCO shall include in its Behavioral Health Strategy Plan and Report efforts towards continued progression of the SAMHSA Integration Framework at all contracted primary and behavioral health Providers.

4.11.1.10 Approach to Behavioral Health Services

4.11.1.10.1 The MCO shall ensure that its clinical standard and operating procedures are consistent with trauma-informed models of care, as defined by SAMHSA²² and reflect a focus on Recovery and resiliency.²³

4.11.1.10.2 The MCO shall offer training inclusive of mental health first aid training, to MCO staff who manage the behavioral health contract and Participating Providers, including Care Managers, physical health Providers, and Providers on Recovery and resiliency, Trauma-Informed Care, and Community Mental Health Services and resources available within the applicable region(s).

4.11.1.10.3 The MCO shall track training rates and monitor usage of Recovery and resiliency and Trauma-Informed Care practices.

4.11.1.10.4 In accordance with Section 4.8.2 (Practice Guidelines and Standards), the MCO shall ensure that Providers, including those who do not serve behavioral health Members, are trained in Trauma-Informed models of Care.

4.11.1.11 Behavioral Health Strategy Plan and Report

4.11.1.11.1 The MCO shall submit to DHHS an initial plan describing its program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health

²² Substance Abuse and Mental Health Services Administration, "Trauma-Informed Approach and Trauma-Specific Interventions," available at <https://www.samhsa.gov/nctic/trauma-interventions>

²³ Substance Abuse and Mental Health Services Administration, "Recovery and Recovery Support," available at <https://www.samhsa.gov/recovery>

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Providers. In accordance with Exhibit O, the initial Plan shall address but not be limited to how the MCO shall:

4.11.1.11.1.1. Assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare;

4.11.1.11.1.2. Assure the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs;

4.11.1.11.1.3. Assure the promotion of Integrated Care;

4.11.1.11.1.4. Reduce Psychiatric Boarding described in Section 4.11.5.17 (Reducing Psychiatric Boarding);

4.11.1.11.1.5. Reduce Behavioral Health Readmissions described in Section 4.11.5.18.4 (Reduction in Behavioral Health Readmissions);

4.11.1.11.1.6. Support the NH 10-Year Plan outlined in Section 4.11.5.15 (Implementation of New Hampshire's 10-Year Mental Health Plan);

4.11.1.11.1.7. Assure the appropriateness of psychopharmacological medication;

4.11.1.11.1.8. Assure access to appropriate services;

4.11.1.11.1.9. Implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and

4.11.1.11.1.10. Other information in accordance with Exhibit O.

4.11.1.11.2 On an annual basis and in accordance with Exhibit O, the MCO shall provide an updated Behavioral Health Strategy Plan and Report which shall include an effectiveness analysis of the initial Plan's program, policies and procedures.

4.11.1.11.2.1. The analysis shall include MCO interventions which require improvement, including improvements in SAMHSA Standard Framework for Levels of Integrated Healthcare, continuity, coordination, and collaboration for physical health and Behavioral Health Services.

4.11.1.12 Collaboration with DHHS

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4.11.1.12.1 At the discretion of DHHS, the MCO shall provide mental health and Substance Use Disorder updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.1.12.2 To improve health outcomes for Members and ensure that delivery of services are provided at the appropriate intensity and duration, the MCO shall meet with behavioral health programs and DHHS at least four (4) times per year to discuss quality assurance activities conducted by the MCO, such as PIPs and APMs, and to review quality improvement plans and outstanding needs.

4.11.1.12.3 Quarterly meetings shall also include a review of progress against deliverables, improvement measures, and select data reports as detailed in Exhibit O. Progress and data reports shall be produced and exchanged between the MCO and DHHS two (2) weeks prior to each quarterly meeting.

4.11.1.12.4 At each meeting, the MCO shall update DHHS on the following topics:

4.11.1.12.4.1. Updates related to the MCO's Behavioral Health Strategy Report and interventions to improve outcomes;

4.11.1.12.4.2. Amendment #5: Intentionally left blank
~~Results of the MCO's quarterly crisis line;~~

4.11.1.12.4.3. Utilization of ACT services and any waitlists for ACT services;

4.11.1.12.4.4. Current EBSE rates;

4.11.1.12.4.5. Current compliance with New Hampshire Hospital discharge performance standards;

4.11.1.12.4.6. Current compliance with ED discharge performance standards for overdoses and Substance Use Disorder;

4.11.1.12.4.7. Updates regarding services identified in Section 4.11 (Behavioral Health);

4.11.1.12.4.8. Updates on Mental Health and Substance Use Disorder PIPs; and

4.11.1.12.4.9. Other topics requested by DHHS.

4.11.1.12.5 For all Members, the MCO shall work in collaboration with DHHS and the NH Suicide Prevention Council to promote

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suicide prevention awareness programs, including the Zero Suicide program.

4.11.1.12.6 The MCO shall submit to DHHS, as specified by DHHS in Exhibit O, its implementation plan for incorporating the "Zero Suicide" program into its operations; the plan shall include, in addition to any other requirements specified in Exhibit O related to the plan, how the MCO shall:

4.11.1.12.6.1. Incorporate efforts to implement standardized provider screenings and other preventative measures; and

4.11.1.12.6.2. Incorporate the Zero Suicide Consensus Guide for Emergency Departments, as described in Section 4.8.2 (Practice Guidelines and Standards).

4.11.1.13 Primary Care Provider Screening for Behavioral Health Needs

4.11.1.13.1 The MCO shall ensure that the need for Behavioral Health Services is systematically identified by and addressed by the Member's PCP at the earliest possible time following initial enrollment of the Member and ongoing thereafter or after the onset of a condition requiring mental health and/or Substance Use Disorder treatment.

4.11.1.13.2 At a minimum, this requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to behavioral health Providers if clinically necessary.

4.11.1.13.3 The MCO shall encourage PCPs and other Providers to use a screening tool approved by DHHS, as well as other mechanisms to facilitate early identification of behavioral health needs.

4.11.1.13.4 The MCO shall require all PCPs and behavioral health Providers to incorporate the following domains into their screening and assessment process:

4.11.1.13.4.1. Demographic,

4.11.1.13.4.2. Medical,

4.11.1.13.4.3. Substance Use Disorder,

4.11.1.13.4.4. Housing,

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4.11.1.13.4.5. Family & support services,

4.11.1.13.4.6. Education,

4.11.1.13.4.7. Employment and entitlement,

4.11.1.13.4.8. Legal, and

4.11.1.13.4.9. Risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

4.11.1.13.5 The MCO shall require that pediatric Providers ensure that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

4.11.1.13.5.1. Depression screening (e.g., PHQ 2 & 9); and

4.11.1.13.5.2. Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

4.11.1.14 Referrals

4.11.1.14.1 The MCO shall ensure through its Health Risk Assessment Screening (described in Section 4.10.2) and its Risk Scoring and Stratification methodology that Members with a potential need for Behavioral Health Services, particularly Priority Population Members as described in Section 4.10.3 (Priority Populations), are appropriately and timely referred to behavioral health Providers if co-located care is not available.

4.11.1.14.2 This shall include education about Behavioral Health Services, including the Recovery process, Trauma-Informed Care, resiliency, CMH Programs/CMH Providers and Substance Use Disorder treatment Providers in the applicable region(s).

4.11.1.14.3 The MCO shall develop a referral process to be used by Participating Providers, including what information shall be exchanged and when to share this information, as well as notification to the Member's Care Manager.

4.11.1.14.4 The MCO shall develop and provide Provider education and training materials to ensure that physical health providers know

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when and how to refer Members who need specialty Behavioral Health Services.

4.11.1.14.5 The MCO shall ensure that Members with both physical health and behavioral health needs are appropriately and timely referred to their PCPs for treatment of their physical health needs when Integrated Care is not available.

4.11.1.14.6 The MCO shall develop a referral process to be used by its Providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health Provider.

4.11.1.14.7 The MCO shall develop and provide Provider education and training materials to ensure that behavioral health Providers know when and how to refer Members who need physical health services.

4.11.1.15 Prior Authorization

4.11.1.15.1 As of September, 2017, the MCO shall comply with the Prior Authorization requirements of House Bill 517 for behavioral health drugs, including use of the universal online Prior Authorization form provided by DHHS for drugs used to treat mental illness.

4.11.1.15.2 The MCO shall ensure that any Subcontractor, including any CMH Program/CMH Provider, complies with all requirements included in the bill.

4.11.1.16 Comprehensive Assessment and Care Plans for Behavioral Health Needs

4.11.1.16.1 The MCO's policies and procedures shall identify the role of physical health and behavioral health Providers in assessing a Member's behavioral health needs as part of the Comprehensive Assessment and developing a care plan.

4.11.1.16.2 For Members with chronic physical conditions that require ongoing treatment who also have behavioral health needs and who are not already treated by an integrated Provider team, the MCO shall ensure participation of the Member's physical health Provider (PCP or specialist), behavioral health Provider, and, if applicable, Care Manager, in the Comprehensive Assessment and care plan development process as well as the ongoing provision of services.

4.11.1.17 Written Consent

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4.11.1.17.1 Per 42 CFR Part 2 and NH Code of Administrative Rules, Chapter He-M 309, the MCO shall ensure that both the PCP and behavioral health Provider request written consent from Members to release information to coordinate care regarding mental health services or Substance Use Disorder services, or both, and primary care.

4.11.1.17.2 The MCO shall conduct a review of a sample of case files where written consent was required to determine if a release of information was included in the file.

4.11.1.17.3 The MCO shall report instances in which consent was not given, and, if possible, the reason why, and submit this report in accordance with Exhibit O.

4.11.1.18 Coordination Among Behavioral Health Providers

4.11.1.18.1 The MCO shall support communication and coordination between mental health and Substance Use Disorder service Providers and PCPs by providing access to data and information when the Member consent has been documented in accordance with State and federal law, including:

4.11.1.18.1.1. Assignment of a responsible party to ensure communication and coordination occur and that Providers understand their role to effectively coordinate and improve health outcomes;

4.11.1.18.1.2. Determination of the method of mental health screening to be completed by Substance Use Disorder service Providers;

4.11.1.18.1.3. Determination of the method of Substance Use Disorder screening to be completed by mental health service Providers;

4.11.1.18.1.4. Description of how treatment plans shall be coordinated among Behavioral Health Service Providers; and

4.11.1.18.1.5. Assessment of cross training of behavioral health Providers (i.e. mental health Providers being trained on Substance Use Disorder issues and Substance Use Disorder Providers being trained on mental health issues).

4.11.1.19 Member Service Line

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4.11.1.19.1 As further outlined in Section 4.4.4.3 (Member Call Center), the MCO shall operate a Member Services toll-free phone line that is used by all Members, regardless of whether they are calling about physical health or Behavioral Health Services.

4.11.1.19.2 The MCO shall not have a separate number for Members to call regarding Behavioral Health Services, but may either route the call to another entity or conduct a transfer to another entity after identifying and speaking with another individual at the receiving entity to accept the call (i.e., a "warm transfer").

4.11.1.19.3 If the MCO's nurse triage/nurse advice line is separate from its Member Services line, the nurse triage/nurse advice line shall be the same for all Members, regardless of whether they are calling about physical health and/or behavioral health term services.

4.11.1.20 Provision of Services Required by Courts

4.11.1.20.1 The MCO shall pay for all NH Medicaid State Plan services, to include assessment and diagnostic evaluations, for its Members as ordered by any court within the State. Court ordered treatment services shall be delivered at an appropriate level of care.

4.11.1.21 Sentinel Event Review

4.11.1.21.1 The MCO shall participate in sentinel event reviews conducted in accordance with the DHHS policy as requested by DHHS.

4.11.1.22 Behavioral Health Member Experience of Care Survey

4.11.1.22.1 The MCO shall contract with a third party to conduct a Member behavioral health experience of care survey on an annual basis.

4.11.1.22.2 The survey shall be designed by DHHS and the MCO's results shall be reported in accordance with Exhibit O. The survey shall comply with necessary NCQA Health Plan Accreditation standards.

4.11.2 Emergency Services

4.11.2.1 ~~[Amendment #5] Intentionally left blank. The MCO shall ensure, through its contracts with local Providers, that statewide crisis lines and Emergency Services are in place twenty-four (24) hours a day, seven (7) days a week for Members experiencing a mental health or Substance Use Disorder crisis.~~

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4.11.2.2 The MCO shall ensure that all types of behavioral health crisis response services are included, such as mobile crisis and office-based crisis services.

4.11.2.2.1 [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #7:] For the period July 1, 2021 through August 31, 2024 June 30, 2023 June 30, December 30, 2022, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

4.11.2.3 Emergency Services shall be accessible to Members anywhere in the region served by the CMH Program/Provider.

4.11.2.4 [Amendment #5] Described in Section 3.15.2 (Other MCO Required Staff), and pursuant to administrative rule, ~~these crisis lines~~ and Emergency Services teams shall employ clinicians and certified Peer Support Specialists.

4.11.2.5 [Amendment #5] Intentionally left blank. ~~The MCO shall be able to demonstrate during the Readiness Review process that its crisis line can effectively link Members to Emergency Services or other behavioral health crisis services and supports.~~

4.11.2.6 As directed by DHHS, and at the MCO's sole expense, the MCO shall contract with DHHS specified crisis service teams for both adults and children to meet these requirements.

4.11.2.7 At the discretion of DHHS, the MCO shall provide updates as requested by DHHS during regular Behavioral Health meetings between the MCO and DHHS on innovative and cost-effective models of providing mental health crisis and emergency response services that provide the maximum clinical benefit to the Member while also meeting DHHS's objectives to reduce admissions and increase community tenure.

4.11.2.8 [Amendment #5] Intentionally left blank. ~~In accordance with Exhibit O, the MCO shall submit quarterly crisis line data that lists the total calls received by the statewide crisis line attributable to Members, including the ultimate disposition of the call (e.g., educational, referral to care, no referral to care, etc.).~~

4.11.3 Behavioral Health Training Plan

4.11.3.1 In accordance with Exhibit O, the MCO shall develop a behavioral health training plan each year outlining how it will strengthen behavioral health capacity for Members within the state and support the efforts of CMH Programs/Providers to hire, retain and train qualified staff.

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4.11.3.2 The MCO shall coordinate with DHHS to reduce duplication of training efforts and submit the training plan to DHHS prior to program start and annually thereafter, inclusive of the training schedule and target Provider audiences.

4.11.3.3 As part of the training plan, the MCO shall promote Provider competence and opportunities for skill-enhancement through training opportunities and consultation, either through the MCO or other consultants with expertise in the area focused on through the training.

4.11.3.4 The MCO training plan shall include at least twenty-four (24) hours of training designed to sustain and expand the use of the:

4.11.3.4.1 Trauma Focused Cognitive Behavioral Therapy;

4.11.3.4.2 Trauma Informed Care;

4.11.3.4.3 Motivational Interviewing;

4.11.3.4.4 Interventions for Nicotine Education and Treatment;

4.11.3.4.5 Dialectical Behavioral Therapy (DBT);

4.11.3.4.6 Cognitive Behavioral Therapy;

4.11.3.4.7 Client Centered Treatment Planning;

4.11.3.4.8 Family Psychoeducation;

4.11.3.4.9 Crisis Intervention;

4.11.3.4.10 SBIRT for PCPs;

4.11.3.4.11 Depression Screening for PCPs;

4.11.3.4.12 Managing Cardiovascular and Metabolic Risk for People with SMI; and

4.11.3.4.13 MAT (including education on securing a SAMHSA waiver to provide MAT and, for Providers that already have such waivers, the steps required to increase the number of waiver slots).

4.11.3.5 The Training Plan shall also outline the MCO's plan to develop and administer the following behavioral health trainings for all Providers in all settings that are involved in the delivery of Behavioral Health Services to Members:

4.11.3.5.1 Training for primary care clinics on best practices for behavioral health screening and Integrated Care for common depression, anxiety and Substance Use Disorders;

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4.11.3.5.2 Training to physical health Providers on how and when to refer Members for Behavioral Health Services;

4.11.3.5.3 Training to behavioral health Providers on how and when to refer Members for physical health services;

4.11.3.5.4 Cross training to ensure that mental health Providers receive Substance Use Disorder training and Substance Use Disorder Providers receive mental health training;

4.11.3.5.5 New models for behavioral health interventions that can be implemented in primary care settings;

4.11.3.5.6 Clinical care integration models to Participating Providers; and

4.11.3.5.7 Community-based resources to address social determinants of health.

4.11.3.6 The MCO shall offer a minimum of two (2) hours of training each Agreement year to all contracted CMH Program/Provider staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the DHHS's objective of reducing the number of suicides in NH.

4.11.3.7 The MCO shall provide, on at least an annual basis, training on appropriate billing practices to Participating Providers. DHHS reserves the discretion to change training plan areas of focus in accordance with programmatic changes and objectives.

4.11.3.8 In accordance with Exhibit O, the MCO shall summarize in the annual Behavioral Health Strategy Plan and Report the training that was provided, a copy of the agenda for each training, a participant registration list, and a summary, for each training provided, of the evaluations done by program participants, and the proposed training for the next fiscal year.

4.11.4 Parity

4.11.4.1 The MCO and its Subcontractors shall comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438, subpart K, which prohibits discrimination in the delivery of mental health and Substance Use Disorder services and in the treatment of Members with, at risk for, or recovering from a mental health or Substance Use Disorder.

4.11.4.2 Semi-Annual Report on Parity

4.11.4.2.1 The MCO shall complete the DHHS Parity Compliance Report which shall include, at a minimum:

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4.11.4.2.1.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCO pursuant to DHHS criteria;

4.11.4.2.1.2. All Member grievances and appeals regarding a parity violation and resolutions;

4.11.4.2.1.3. The processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for mental health or Substance Use Disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for medical/surgical benefits in the same classification;

4.11.4.2.1.4. A comparison of payment for services that ensure comparable access for people with mental health diagnoses; and

4.11.4.2.1.5. Any other requirements identified in Exhibit O. [61 Fed. Reg. 18413, 18414 and 18417 (March 30, 2016)]

4.11.4.2.2 The MCO shall review its administrative and other practices, including those of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance issued by State and federal entities.

4.11.4.2.3 The MCO shall annually submit a certification signed by the CEO and chief medical officer (CMO) stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the MCO for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and federal Mental Health Parity Law and any guidance issued by State and federal entities.

4.11.4.2.4 If the MCO determines that any administrative, clinical, or utilization practices were not in compliance with relevant requirements of the federal Mental Health Parity Law or guidance issued by State and federal entities during the calendar year, the certification shall state that not all practices were in compliance with federal Mental Health Parity Law or any guidance issued by state or federal entities and shall include a list of the practices not in

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compliance and the steps the MCO has taken to bring these practices into compliance.

4.11.4.2.5 A Member enrolled in any MCO may file a complaint with DHHS at nhparity@dhhs.nh.gov if services are provided in a way that is not consistent with applicable federal Mental Health Parity laws, regulations or federal guidance.

4.11.4.2.6 As described in Section 4.4 (Member Services), the MCO shall describe the parity compliant process, including the appropriate contact information, in the Member Handbook.

4.11.4.3 Prohibition on Lifetime or Annual Dollar Limits

4.11.4.3.1 The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or Substance Use Disorder benefits. [42 CFR 438.905(b)]

4.11.4.4 Restrictions on Treatment Limitations

4.11.4.4.1 The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or Substance Use Disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits. [42 CFR 438.910(b)(1)]

4.11.4.4.2 The MCO shall not apply any cumulative financial requirements for mental health or Substance Use Disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. [42 CFR 438.910(c)(3)]

4.11.4.4.3 If an MCO Member is provided mental health or Substance Use Disorder benefits in any classification of benefit, the MCO shall provide mental health or Substance Use Disorder benefits to Members in every classification in which medical/surgical benefits are provided. [42 CFR 438.910(b)(2)]

4.11.4.4.4 The MCO shall not impose Non-Quantitative Treatment Limits for mental health or Substance Use Disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or Substance Use Disorder benefits in the classification are comparable to, and are applied no

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more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [42 CFR 438.910(d)]

4.11.4.5 Medical Necessity Determination

4.11.4.5.1 The MCO shall provide the criteria for medical necessity determinations for mental health or Substance Use Disorder benefits to any Member, potential Member, or Participating Provider upon request and at no cost.

4.11.5 Mental Health

4.11.5.1 Contracting for Community Mental Health Services

4.11.5.1.1 The MCO shall contract with CMH Programs and CMH Providers for the provision of Community Mental Health Services described in NH Code of Administrative Rules, Chapter He-M 426 on behalf of Medicaid Members who qualify for such services in accordance with He-M 401.24

4.11.5.1.2 The MCO's contract shall provide for monitoring of CMH Program/CMH Provider performance through quality metrics and oversight procedures of the CMH Program/CMH Provider.

4.11.5.1.3 The contract shall be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.14.2 (Contracts with Subcontractors). The contract shall, at minimum, address:

4.11.5.1.3.1. The scope of services to be covered;

4.11.5.1.3.2. Compliance with the requirements of this Agreement and all applicable State and federal laws, rules and regulations;

4.11.5.1.3.3. The role of the MCO versus the CMH Program/CMH Provider;

4.11.5.1.3.4. Procedures for communication and coordination between the MCO and the CMH Program/CMH Provider, other Providers serving the same Member and DHHS;

4.11.5.1.3.5. Data sharing on Members;

4.11.5.1.3.6. Data reporting between the CMH Program/CMH Provider and the MCO and DHHS; and

²⁴ Available at http://www.gencourt.state.nh.us/rules/About_Rules/listagencies.htm

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4.11.5.1.3.7. Oversight, enforcement, and remedies for contract disputes.

4.11.5.2 Payment to Community Mental Health Programs and Community Mental Health Providers

4.11.5.2.1 The MCO is required to enter into a capitated payment arrangement with CMH Programs to deliver Community Mental Health Services, providing for reimbursement on terms specified by DHHS in guidance.

4.11.5.2.2 The MCO shall reach agreements and enter into contracts with all CMH Programs that meet the terms specified by DHHS no later than ninety (90) calendar days after Agreement execution.

4.11.5.2.2.1. [Amendment #1:] For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in March 2019.
~~[Base Contract:] For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in January 2019.~~

4.11.5.2.3 [Amendment #5:] The MCO shall be subject to payment requirements described in Section 4.15.5 (Provider Payments: Community Mental Health Programs).

4.11.5.3 Provision of Community Mental Health Services

4.11.5.3.1 The MCO shall ensure that Community Mental Health Services are provided in accordance with the Medicaid State Plan and He-M 401.02, He-M 403.02 and He-M 426.

4.11.5.3.2 This includes, but is not limited, to ensuring that the full range of Community Mental Health Services are appropriately provided to eligible Members.

4.11.5.3.3 Eligible Members shall receive an individualized service plan created and updated regularly, consistent with State and federal requirements, including but not limited to He-M 401.

4.11.5.3.4 Eligible Members shall be offered the provisions of supports for illness self-management and Recovery;

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4.11.5.3.5 Eligible Members shall be provided with coordinated care when entering and leaving a designated receiving facility.

4.11.5.3.6 The MCO shall ensure that all Providers providing Community Mental Health Services comply with the requirements of He-M 426.

4.11.5.3.7 As described in He-M 400, a Member may be deemed eligible for Community Mental Health Services if the Member has a:

4.11.5.3.7.1. Severe or persistent mental illness (SPMI) for an adult;

4.11.5.3.7.2. SMI for an adult;

4.11.5.3.7.3. SPMI or SMI with low service utilization for an adult;

4.11.5.3.7.4. SED for a child; or

4.11.5.3.7.5. SED and interagency involvement for a child.

4.11.5.3.8 Any MCO quality monitoring or audits of the performance of the CMH Programs/CMH Providers shall be available to DHHS upon request.

4.11.5.3.9 To improve health outcomes for Members and ensure that the delivery of services is provided at the appropriate intensity and duration, the MCO shall meet with CMH Programs/CMH Providers and DHHS at least quarterly to coordinate data collection and ensure data sharing.

4.11.5.3.10 At a minimum, this shall include sharing of quality assurance activities conducted by the MCO and DHHS and a review of quality improvement plans, data reports, Care Coordination activities, and outstanding needs. Reports shall be provided in advance of quarterly meetings.

4.11.5.3.11 The MCO shall work in collaboration with DHHS, CMH Programs/CMH Providers to support and sustain evidenced-based practices that have a profound impact on Providers and Member outcomes.

4.11.5.4 Comprehensive Assessment and Care Plans

4.11.5.4.1 The MCO shall ensure, through its regular quality improvement activities, on-site reviews for children and youth, and reviews of DHHS administered quality service reviews for adults, that Community Mental Health Services are delivered in the least

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restrictive community based environment possible and based on a person-centered approach where the Member and his or her family's personal goals and needs are considered central in the development of the individualized service plans.

4.11.5.4.2 The MCO shall ensure that initial and updated care plans are based on a Comprehensive Assessment conducted using an evidenced-based assessment tool, such as the NH version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

4.11.5.4.3 If the MCO or a CMH Program/CMH Provider acting on behalf of the MCO elects to permit clinicians to use an evidenced-based assessment tool other than CANS or ANSA, the MCO shall notify and receive approval of the specific tool from DHHS.

4.11.5.4.4 The assessment shall include the domains of the DSRIP Comprehensive Core Standardized Assessment and elements under review in the DHHS quality service review.

4.11.5.4.5 The MCO shall ensure that clinicians conducting or contributing to a Comprehensive Assessment are certified in the use of NH's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within one hundred and twenty (120) calendar days of implementation by DHHS of a web-based training and certification system.

4.11.5.4.6 The MCO shall require that certified clinicians use the CANS, ANSA, or an alternative evidenced-based assessment tool approved by DHHS for any newly evaluated Member and for an existing Member no later than at the Member's first eligibility renewal following certification.

4.11.5.5 Assertive Community Treatment Teams

4.11.5.5.1 The MCO shall work in collaboration with DHHS and CMH Programs/CMH Providers to ensure that ACT teams include at least one certified Peer Support Specialist and are available to Medicaid Members twenty-four (24) hours a day, seven (7) days a week, with on-call availability from 12:00 am to 8:00 am.

4.11.5.5.2 At the sole discretion of DHHS, as defined in separate guidance, the MCO shall reimburse CMH Programs/CMH Providers at an enhanced rate for the cost of providing at least fair fidelity ACT services to eligible Medicaid Members.

4.11.5.5.3 The MCO shall obtain annual fidelity review reports from DHHS to inform the ACT team's adherence to fidelity.

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4.11.5.5.4 In collaboration with DHHS, the MCO shall support CMH Programs/CMH Providers to achieve program improvement goals outlined in the ACT Quality Improvement Plan on file with DHHS to achieve full implementation of ACT.

4.11.5.5.5 In accordance with Exhibit O, the MCO shall report quarterly on the rate at which the MCO's Medicaid Members eligible for Community Mental Health Services are receiving ACT services.

4.11.5.5.6 The MCO shall provide updates on any waitlists maintained for ACT services during regular behavioral health meetings between the MCO and DHHS.

4.11.5.6 Mental Health Performance Improvement Project

4.11.5.6.1 [Amendment #8:] As outlined in Section 4.12.3.7 (Performance Improvement Projects), the MCO shall focus on the Department's objectives outlined in the NH MCM Quality Strategy. engage in at least one (1) mental health PIP. The MCO shall satisfy this requirement by implementing a PIP designed to reduce Psychiatric Boarding in the ED.

4.11.5.7 Services for the Homeless

4.11.5.7.1 The MCO shall provide care to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services.

4.11.5.7.2 The MCO shall have one (1) or more Housing Coordinator(s) on staff or under contract to provide in-person housing assistance to Members who are homeless, as described in Section 3.15.1 (Key Personnel).

4.11.5.7.2.1. [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:]
For the period January 1, 2021 through August 31, 2024 June 30, 2023 June 30 December 31, 2022 2021,
the Housing Coordinator position is not required.

4.11.5.7.3 The Housing Coordinator(s) shall coordinate with housing case managers at the CMH Programs, New Hampshire Hospital, the Bureau of Mental Health Services, the Bureau of Housing Supports and other CMH Providers to coordinate referrals.

4.11.5.7.4 In coordination with CMH Programs/CMH Providers, the MCO shall ensure that ACT teams and/or Housing Coordinator(s)

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also provide ongoing mental health and tenancy support services to Members.

4.11.5.7.5 In its contract with CMH Programs/CMH Providers, the MCO shall describe how it shall provide appropriate oversight of CMH Program/CMH Provider responsibilities, including:

4.11.5.7.5.1. Identifying housing options for Members at risk of experiencing homelessness;

4.11.5.7.5.2. Assisting Members in filing applications for housing and gathering necessary documentation;

4.11.5.7.5.3. Coordinating the provision of supportive housing; and

4.11.5.7.5.4. Coordinating housing-related services amongst CMH Programs/CMH Providers, the MCO and NH's Housing Bridge Subsidy Program.

4.11.5.7.6 The contract with CMH Programs/CMH Providers shall require quarterly assessments and documentation of housing status and homelessness for all Members.

4.11.5.7.7 The MCO shall ensure that any Member discharged into homelessness is connected to Care Management as described in Section 4.10.10 (Coordination and Integration with Social Services and Continuity of Care) within twenty-four (24) hours upon release.

4.11.5.8 Supported Employment

4.11.5.8.1 In coordination with CMH Programs/CMH Providers, the MCO shall actively promote EBSE to eligible Members.

4.11.5.8.2 The MCO shall obtain fidelity review reports from DHHS to inform EBSE team's adherence to fidelity with the expectation of at least good fidelity implementation for each CMH Program/CMH Provider.

4.11.5.8.3 In collaboration with DHHS, the MCO shall support the CMH Programs and CMH Providers to achieve program improvement goals outlined in the EBSE Quality Improvement Plan on file with DHHS to achieve full implementation of EBSE.

4.11.5.8.4 Based on data provided by DHHS, the MCO shall support DHHS's goals to ensure that at least nineteen percent (19%) of adult Members are engaged in EBSE services and that employment status is updated by the CMH Program/CMH Provider on a quarterly basis.

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4.11.5.8.5 The MCO shall report the EBSE rate to DHHS in accordance with Exhibit O and provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.9 Illness Management and Recovery

4.11.5.9.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of and increased penetration rates of illness management and Recovery to Members with SMI and SPMI.

4.11.5.9.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.10 Dialectical Behavioral Therapy

4.11.5.10.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of DBT to Members with diagnoses, including but not limited to SMI, SPMI, and Borderline Personality Disorder.

4.11.5.10.2 The MCO shall provide updates, such as the rate at which eligible Members receive meaningful levels of DBT services, as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.11 Peer Recovery Support Services

4.11.5.11.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of PRSS provided by Peer Recovery Programs in a variety of settings such as CMH Programs, New Hampshire Hospital, primary care clinics, and EDs.

4.11.5.11.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.12 Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems

4.11.5.12.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems²⁵ for children and youth Members experiencing anxiety, depression, trauma and conduct issues.

²⁵Available at: http://www.practicewise.com/portals/0/match_public/index.html

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4.11.5.12.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.13 First Episode Psychosis

4.11.5.13.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of programming to address early symptoms of psychosis.

4.11.5.13.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.14 Child Parent Psychotherapy

4.11.5.14.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote delivery of Child Parent Psychotherapy for young children.

4.11.5.14.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.15 Implementation of New Hampshire's 10-Year Mental Health Plan

4.11.5.15.1 In accordance with Exhibit O, the MCO shall actively support the implementation of NH's 10-Year Mental Health Plan, updated periodically, to reinforce implementation of priorities outlined in the plan.

4.11.5.16 Changes in Healthy Behavior

4.11.5.16.1 The MCO shall promote Community Mental Health Service recipients' whole health goals to address health disparities.

4.11.5.16.2 Efforts can encompass interventions (e.g., tobacco cessation, "InShape") or other efforts designed to improve health.

4.11.5.16.3 The MCO shall gather smoking status data on all Members and report to DHHS in accordance with Exhibit O.

4.11.5.16.4 The MCO shall support CMH Programs/CMH Providers to establish incentive programs for Members to increase their engagement in healthy behavior change initiatives.

4.11.5.17 Reducing Psychiatric Boarding

4.11.5.17.1 For each hospital in its network, the MCO shall have on its own staff or contract with clinical Providers who are credentialed

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by the hospital (i.e., "hospital-credentialed Providers") to provide services to reduce Psychiatric Boarding stays.

4.11.5.17.1.1. [Amendment #10:] ~~[Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:]~~ For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023 June 30, December 31, 2022 2024~~, the Psychiatric Boarding program's hospital-credentialed Provider position(s) described in Sections 4.11.5.17.1 through 4.11.5.17.4, and 4.11.5.17.6 are not required.

4.11.5.17.2 In meeting this requirement, the MCO cannot use CMH Programs and CMH Providers and shall ensure that its hospital-credentialed Providers are in addition to any capacity provided by CMH Programs and CMH Providers.

4.11.5.17.3 The MCO shall supply a sufficient number of hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to, or at risk for, Psychiatric Boarding.

4.11.5.17.4 The number of such hospital-credentialed Providers shall be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed.

4.11.5.17.5 [Amendment #8:] The initial on-site assistance provided within these required timelines shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or other State determined IMDs for mental illness or Substance Use Disorder services.

4.11.5.17.6 Each such hospital-credentialed Provider shall have the clinical expertise, inclusive of prescribing authority, to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required.

4.11.5.17.7 At the request of DHHS, the MCO shall participate in meetings with hospitals to address Psychiatric Boarding.

4.11.5.17.8 The MCO shall pay no less than the rate paid by NH Medicaid FFS program for all inpatient and outpatient service categories for billable services related to psychiatric boarding.

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4.11.5.17.9 [Amendment #8:] The MCO's capitation rates related to psychiatric services shall reflect utilization levels consistent with best practices for clinical path protocols, ED Psychiatric Boarding services, and discharge/readmission management at or from New Hampshire Hospital or other State determined IMDs for mental illness or Substance Use Disorder services.

4.11.5.17.10 The MCO shall describe its plan for reducing Psychiatric Boarding in its Annual Behavioral Health Strategy Plan and Report, in accordance with Exhibit O.

4.11.5.17.11 At minimum, the plan shall address how:

4.11.5.17.11.1. The MCO identifies when its Members are in the ED awaiting psychiatric placement or in a hospital setting awaiting an inpatient psychiatric bed;

4.11.5.17.11.2. Policies for ensuring a prompt crisis team consultation and face-to-face evaluation;

4.11.5.17.11.3. Strategies for identifying placement options or alternatives to hospitalization; and

4.11.5.17.11.4. Coordination with the CMH Programs/CMH Providers serving Members.

4.11.5.17.12 In accordance with Exhibit O, the MCO shall provide a monthly report on the number of its Members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult Members, and the rate of recidivism for Psychiatric Boarding.

4.11.5.18 [Amendment #8:] New Hampshire Hospital and Other State Determined IMDs for Mental Illness

4.11.5.18.1 [Amendment #8:] Agreements for New Hampshire Hospital Agreement and Other State Determined IMDs for Mental Illness

4.11.5.18.1.1. [Amendment #8:] The MCO shall maintain a written collaborative agreement with New Hampshire Hospital, ~~NH's State operated inpatient psychiatric facility~~ and other State determined IMDs for mental illness.

4.11.5.18.1.2. [Amendment #8:] This collaborative agreement shall be subject to the approval of DHHS and shall address the ADA requirement that Members be

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served in the most integrated setting appropriate to their needs, include the responsibilities of the CMH Program/CMH Provider to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital and other State determined IMDs for mental illness.

4.11.5.18.1.3. [Amendment #8:] The collaborative agreement shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to New Hampshire Hospital and other State determined IMDs for mental illness.

4.11.5.18.1.4. [Amendment #8:] Prior to admission to New Hampshire Hospital or other State determined IMDs for mental illness, the MCO shall ensure that a crisis team consultation has been completed for all Members evaluated by a licensed physician or psychologist.

4.11.5.18.1.5. The MCO shall ensure that a face-to-face evaluation by a mandatory pre-screening agent is conducted to assess eligibility for emergency involuntary admission to New Hampshire Hospital and determine whether all available less restrictive alternative services and supports are unsuitable.

4.11.5.18.2 Discharge Planning

4.11.5.18.2.1. [Amendment #8:] It is the policy of DHHS to avoid discharges from inpatient care at New Hampshire Hospital or other State determined IMDs for mental illness, to homeless shelters and to ensure the inclusion of an appropriate living situation as an integral part of all discharge planning ~~from New Hampshire Hospital.~~

4.11.5.18.2.2. The MCO shall track any Member discharges that the MCO, through its Provider network, was unable to place into the community and Members who instead were discharged to a shelter or into homelessness.

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4.11.5.18.2.3. [Amendment #8:] Also included in Section 3.15.2 (Other MCO Required Staff), the MCO shall designate an off-site on-site liaison with privileges, as required by New Hampshire Hospital, to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to New Hampshire Hospital or other State determined IMDs for mental illness.

4.11.5.18.2.4. [Amendment #8:] Except for participation in the Administrative Review Committee, the liaison shall actively participate in New Hampshire Hospital and other State determined IMDs for mental illness treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least restrictive environment complying with the ADA and other applicable State and federal regulations.

4.11.5.18.2.5. [Amendment #8:] The liaison shall actively participate, and assist New Hampshire Hospital and other State determined IMDs for mental illness staff in the development of a written discharge plan within twenty-four (24) hours of admission.

4.11.5.18.2.6. [Amendment #8:] The MCO shall ensure that the final New Hampshire Hospital or other State determined IMDs for mental illness discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight percent (98%) of Members discharged.

4.11.5.18.2.7. The MCO shall ensure that the discharge progress note shall be provided to the aftercare Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.11.5.18.2.8. For ACT team service recipients, the MCO shall ensure that the discharge progress note is provided to the Provider within twenty-four (24) hours of Member discharge.

4.11.5.18.2.9. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

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4.11.5.18.2.10. [Amendment #8:] The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from New Hampshire Hospital and other State determined IMDs for mental illness in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.11.5.18.2.11. The performance metric shall be that one hundred percent (100%) of Members discharged shall have been attempted to be contacted within three (3) business days.

4.11.5.18.2.12. For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the aftercare Provider and request that the aftercare Provider make contact with the Member within twenty-four (24) hours.

4.11.5.18.2.13. The MCO shall ensure an appointment with a CMH Program/CMH Provider or other appropriate mental health clinician is scheduled and that transportation has been arranged for the appointment prior to discharging a Member.

4.11.5.18.2.14. Such appointment shall occur within seven (7) calendar days after discharge.

4.11.5.18.2.15. ACT team service recipients shall be seen within twenty-four (24) hours of discharge.

4.11.5.18.2.16. For persons discharged from psychiatric hospitalization who are not a current client of the applicable CMH Program/CMH Provider, the Member shall have an intake appointment that is scheduled to occur within seven (7) calendar days after discharge.

4.11.5.18.2.17. [Amendment #8:] The MCO shall work with DHHS and the applicable CMH Program/CMH Provider to review cases of Members that New Hampshire Hospital and other State determined IMDs for mental illness ~~has~~ have indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

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4.11.5.18.3 Administrative Days and Post Stabilization Care Services

4.11.5.18.3.1. [Amendment #8:] The MCO shall perform in-reach activities to New Hampshire Hospital and other State determined IMDs for mental illness designed to accomplish transitions to the community.

4.11.5.18.3.2. [Amendment #8:] Administrative days and post stabilization care services are inpatient hospital days associated with Members who no longer require acute care but are left in New Hampshire Hospital and other State determined IMDs for mental illness. ~~the hospital.~~

4.11.5.18.3.3. [Amendment #8:] The MCO shall pay New Hampshire Hospital and other State determined IMDs for mental illness for services delivered under the inpatient and outpatient service categories at rates no less than those paid by the NH Medicaid FFS program, inclusive of both State and federal share of the payment, if a Member cannot be discharged due to failure to provide appropriate community-based care and services.

4.11.5.18.4 Reduction in Behavioral Health Readmissions

4.11.5.18.4.1. [Amendment #8:] The MCO shall describe a reduction in readmissions plan in its annual Behavioral Health Strategy Plan and Report in accordance with Exhibit O, subject to approval by DHHS, to monitor the thirty (30)-day and one hundred and eighty (180)-day readmission rates to New Hampshire Hospital, other State determined IMDs for mental illness, designated receiving facilities and other equivalent facilities to review Member specific data with each of the CMH Programs/CMH Providers, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce thirty (30)-day and one hundred and eighty (180)-day readmission.

4.11.5.18.4.2. [Amendment #8:] Avoiding readmission is associated with the delivery of a full array of Medically Necessary outpatient medication and Behavioral Health Services in the ninety (90) days after discharge from New Hampshire Hospital and other State determined

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IMDs for mental illness; the MCO shall ensure provision of appropriate service delivery in the ninety (90) days after discharge.

4.11.5.18.4.3. [Amendment #8:] For Members with readmissions to any inpatient psychiatric setting within thirty (30) days and one hundred and eighty (180) days, the MCO shall report on the mental health and related service utilization that directly preceded readmission in accordance with Exhibit O. This data shall be shared with the Member's CMH Program/CMH Provider, if applicable, and DHHS in order to evaluate if appropriate levels of care were provided to decrease the likelihood of re-hospitalization.

4.11.6 Substance Use Disorder

4.11.6.1 The MCO's policies and procedures related to Substance Use Disorder shall be in compliance with State and federal law, including but not limited to, Chapter 420-J, Section J:15 through Section J:19 and shall comply with all State and federal laws related to confidentiality of Member behavioral health information.

4.11.6.2 In addition to services covered under the Medicaid State Plan, the MCO shall cover the services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder benefits. [42 CFR 438, subpart K; 42 CFR 438.3(e)(1)(ii)]

4.11.6.3 The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.11.6.4 Contracting for Substance Use Disorder

4.11.6.4.1 The MCO shall contract with Substance Use Disorder service programs and Providers to deliver Substance Use Disorder services for eligible Members, as defined in He-W 513.²⁶

4.11.6.4.2 The contract between the MCO and the Substance Use Disorder programs and Participating Providers shall be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.14.2 (Contracts with Subcontractors).

4.11.6.4.3 The contract shall, at minimum, address the following:

4.11.6.4.3.1. The scope of services to be covered;

²⁶ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html

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4.11.6.4.3.2. Compliance with the requirements of this Agreement and applicable State and federal law;

4.11.6.4.3.3. The role of the MCO versus the Substance Use Disorder program and/or Provider;

4.11.6.4.3.4. procedures for communication and coordination between the MCO and the Substance Use Disorder program and/or Provider;

4.11.6.4.3.5. Other Providers serving the same Member, and DHHS as applicable;

4.11.6.4.3.6. The approach to payment, including enhanced payment for ACT services;

4.11.6.4.3.7. Data sharing on Members;

4.11.6.4.3.8. Data reporting between the Substance Use Disorder programs and/or Providers and the MCO, and DHHS as applicable; and

4.11.6.4.3.9. Oversight, enforcement, and remedies for contract disputes.

4.11.6.4.4 The contract shall provide for monitoring of Substance Use Disorder service performance through quality metrics and oversight procedures specified in the contract.

4.11.6.4.5 When contracting with Peer Recovery Programs, the MCO shall contract with all Willing Providers in the State through the PRSS Facilitating Organization or other accrediting body approved by DHHS, unless the Provider requests a direct contract.

4.11.6.4.6 The MCO shall reimburse Peer Recovery Programs in accordance with rates that are no less than the equivalent DHHS FFS rates.

4.11.6.4.7 When contracting with methadone clinics, the MCO shall contract with and have in its network all Willing Providers in the state.

4.11.6.5 Payment to Substance Use Disorder Providers

4.11.6.5.1 The MCO shall reimburse Substance Use Disorder Providers in accordance with rates that are no less than the equivalent DHHS FFS rates.

4.11.6.5.2 The MCO need not pay using DHHS's FFS mechanism where the MCO's contract with the Provider meets the following requirements:

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4.11.6.5.2.1. Is subject to enhanced reimbursement for MAT, as described in as outlined in this section; or

4.11.6.5.2.2. Falls under a DHHS-approved APM, the standards and requirements for obtaining DHHS approval are further described in Section 4.14 (Alternative Payment Models).

4.11.6.5.3 DHHS shall provide the MCO with sixty (60) calendar days' advance notice prior to any change to reimbursement.

4.11.6.5.4 In accordance with Exhibit O, the MCO shall develop and submit to DHHS, a payment plan for offering enhanced reimbursement to qualified physicians who are SAMHSA certified to dispense or prescribe MAT.

4.11.6.5.5 The plan shall indicate at least two (2) tiers of enhanced payments that the MCO shall make to qualified Providers based on whether Providers are certified and providing MAT to up to thirty (30) Members per quarter (i.e., tier one (1) Providers) or certified and providing MAT to up to one hundred (100) Members per quarter (i.e., tier two (2) Providers).

4.11.6.5.6 The tier determinations that qualify Providers for the MCO's enhanced reimbursement policy shall reflect the number of Members to whom the Provider is providing MAT treatment services, not the number of patients the Provider is certified to provide MAT treatment to.

4.11.6.5.7 The MCO shall develop at least one (1) APM designed to increase access to MAT for Substance Use Disorder and one (1) APM (such as a bundled payment) for the treatment of babies born with NAS.

4.11.6.6 Provision of Substance Use Disorder Services

4.11.6.6.1 The MCO shall ensure that Substance Use Disorder services are provided in accordance with the Medicaid State Plan and He-W 513. This includes, but is not limited to:

4.11.6.6.1.1. Ensuring that the full continuum of care is appropriately provided to eligible Members;

4.11.6.6.1.2. Ensuring that eligible Members are provided with Recovery support services; and

4.11.6.6.1.3. Ensuring that eligible Members are provided with coordinated care when entering or leaving a treatment program.

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4.11.6.6.2 The MCO shall ensure that all Providers providing Substance Use Disorder services comply with the requirements of He-W 513.

4.11.6.6.3 The MCO shall work in collaboration with DHHS and Substance Use Disorder programs and/or Providers to support and sustain evidenced-based practices that have a profound impact on Provider and Member outcomes, including, but is not limited to, enhanced rate or incentive payments for evidenced-based practices.

4.11.6.6.4 The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.11.6.6.5 This includes, but is not limited to:

4.11.6.6.5.1. Ensuring that Members at risk of experiencing Substance Use Disorder are assessed using a standardized evidence-based assessment tool consistent with ASAM Criteria; and

4.11.6.6.5.2. Providing access to the full range of services available under the DHHS's Substance Use Disorder benefit, including Peer Recovery Support without regard to whether Peer Recovery Support is an aspect of an additional service provided to the Member.

4.11.6.6.6 The MCO shall make PRSS available to Members both as a standalone service (regardless of an assessment), and as part of other treatment and Recovery services.

4.11.6.6.7 The provision of services to recipients enrolled in an MCO shall not be subject to more stringent service coverage limits than specified under this Agreement or State Medicaid policies.

4.11.6.7 Substance Use Disorder Clinical Evaluations and Treatment Plans

4.11.6.7.1 The MCO shall ensure, through its regular quality improvement activities and reviews of DHHS administered quality monitoring and improvement activities, that Substance Use Disorder treatment services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and their family's personal goals and needs are considered central in the development of the Individualized service plans.

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4.11.6.7.2 A Clinical Evaluation is a biopsychosocial evaluation completed in accordance with SAMHSA Technical Assistance Publication (TAP) 21: Addiction Counseling Competencies.

4.11.6.7.3 The MCO shall ensure that all services provided include a method to obtain clinical evaluations using DSM five (5) diagnostic information and a recommendation for a level of care based on the ASAM Criteria, published in October, 2013 or as revised by ASAM.

4.11.6.7.4 The MCO shall ensure that a clinical evaluation is completed for each Member prior to admission as a part of interim services or within three (3) business days following admission.

4.11.6.7.5 For a Member being transferred from or otherwise referred by another Provider, the Provider shall use the clinical evaluation completed by a licensed behavioral health professional from the referring agency, which may be amended by the receiving Provider.

4.11.6.7.6 The Provider shall complete individualized treatment plans for all Members based on clinical evaluation data within three (3) business days of the clinical evaluation, that address problems in all ASAM 2013 domains which justify the Member's admittance to a given level of care and that include individualized treatment plan goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART).

4.11.6.7.7 The treatment plan shall include the Member's involvement in identifying, developing, and prioritizing goals, objectives, and interventions.

4.11.6.7.8 Treatment plans shall be updated based on any changes in any ASAM domain and no less frequently than every four (4) sessions or every four (4) weeks, whichever is less frequent.

4.11.6.7.9 The treatment plan updates much include:

4.11.6.7.9.1. Documentation of the degree to which the Member is meeting treatment plan goals and objectives;

4.11.6.7.9.2. Modification of existing goals or addition of new goals based on changes in the Member's functioning relative to ASAM domains and treatment goals and objectives;

4.11.6.7.9.3. The counselor's assessment of whether or not the Member needs to move to a different level of

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care based on ASAM continuing care, transfer and discharge criteria; and

4.11.6.7.9.4. The signature of the Member and the counselor agreeing to the updated treatment plan, or if applicable, documentation of the Member's refusal to sign the treatment plan.

4.11.6.8 Substance Use Disorder Performance Improvement Project

4.11.6.8.1 In compliance with the requirements outlined in Section 4.12.3 (Quality Assessment and Performance Improvement Program), the MCO shall, at a minimum, conduct at least one (1) PIP designed to improve the delivery of Substance Use Disorder services.

4.11.6.9 Reporting

4.11.6.9.1 The MCO shall report to DHHS Substance Use Disorder-related metrics in accordance with Exhibit O including, but not limited to, measures related to access to services, engagement, clinically appropriate services, Member engagement in treatment, treatment retention, safety monitoring, and service utilization.

4.11.6.9.2 The MCO shall provide, in accordance with Exhibit O, an assessment of any prescribing rate and pattern outliers and how the MCO plans to follow up with Providers identified as having high-prescribing patterns.

4.11.6.9.3 [Amendment #7:] The MCO shall utilize audit tool(s) provided by or approved by DHHS, collected via one or more mediums made available or approved by DHHS, to assess the activities of Substance Use Disorder Providers and Opioid Treatment Programs (OTPs), to ensure compliance with the He-W 513 rules, He-A 304 rules, and the MCO Contract. The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.11.6.9.3.1. [Amendment #7:] The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.11.6.9.3.2. [Amendment #7:] The MCO shall report on SUD Provider compliance with service provisions

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outlined in the SUD audit tool in accordance with Exhibit O.

4.11.6.9.4 On a monthly basis, the MCO shall provide directly to Participating Providers comparative prescribing data, including the average Morphine Equivalent Dosing (MED) levels across patients and identification of Members with MED at above average levels, as determined by the MED levels across Members.

4.11.6.9.5 The MCO shall also provide annual training to Participating Providers.

4.11.6.10 Services for Members Who are Homeless or At-Risk of Homelessness

4.11.6.10.1 In coordination with Substance Use Disorder programs and/or Providers, the MCO shall provide care to Members who are homeless or at risk of homelessness as described in Section 4.11.5.7 (Services for the Homeless).

4.11.6.11 Peer Recovery Support Services

4.11.6.11.1 In coordination with Peer Recovery Programs and Peer Recovery Coaches, as defined in He-W 513, the MCO shall actively promote delivery of PRSS provided by Peer Recovery Coaches who are also certified Recovery support workers in a variety of settings such as Peer Recovery Programs, clinical Substance Use Disorder programs, EDs, and primary care clinics.

4.11.6.12 Naloxone Availability

4.11.6.12.1 The MCO shall work with each contracted Substance Use Disorder program and/or Provider to ensure that naloxone kits are available on-site and training on naloxone administration and emergency response procedures are provided to program and/or Provider staff at a minimum annually.

4.11.6.13 Prescription Drug Monitoring Program

4.11.6.13.1 The MCO shall include in its Provider agreements the requirement that prescribers and dispensers comply with the NH PDMP requirements, including but not limited to opioid prescribing guidelines.

4.11.6.13.2 The Provider agreements shall require Participating Providers to provide to the MCO, to the maximum extent possible, data on substance dispensing to Members prior to releasing such medications to Members.

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4.11.6.13.3 The MCO shall monitor harmful prescribing rates and, at the discretion of DHHS, may be required to provide ongoing updates on those Participating Providers who have been identified as overprescribing.

4.11.6.14 Response After Overdose

4.11.6.14.1 Whenever a Member receives emergency room or inpatient hospital services as a result of a non-fatal overdose, the MCO shall work with hospitals to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and the participating hospital.

4.11.6.14.2 Whenever a Member discharges themselves against medical advice, the MCO shall make a good faith effort to ensure that the Member receives a clinical evaluation, referral to appropriate treatment, Recovery support services and intense Case Management within forty-eight (48) hours of discharge or the MCO being notified, whichever is sooner.

4.11.6.15 Limitations on Prior Authorization Requirements

4.11.6.15.1 To the extent permitted under State and federal law, the MCO shall cover MAT.

4.11.6.15.2 Methadone received at a methadone clinic shall not require Prior Authorization.

4.11.6.15.3 Methadone used to treat pain shall require Prior Authorization.

4.11.6.15.3.1. Any Prior Authorization for office based MAT shall comply with RSA 420-J:17 and RSA 420-J:18.

4.11.6.15.4 The MCO shall not impose any Prior Authorization requirements for MAT urine drug screenings (UDS) unless a Provider exceeds thirty (30) UDSs per month per treated Member.

4.11.6.15.4.1. In the event a Provider exceeds thirty (30) UDS per month per treated Member, the MCO shall impose Prior Authorization requirements on usage.

4.11.6.15.5 The MCO is precluded from imposing any Prior Authorization on screening for multiple drugs within a daily drug screen.

4.11.6.15.6 [Amendment #6:] The MCO may require prior authorization for SUD treatments, excluding MAT services as

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~~described in Section 4.11.6.15.3.1. The MCO shall cover without Prior Authorization or other Utilization Management restrictions any treatments identified as necessary by a clinician trained in the use and application of the ASAM Criteria.~~

4.11.6.15.6.1. [Amendment #6:] The MCO shall utilize ASAM Criteria when determining medical necessity for continuation of covered services.

4.11.6.15.6.2. [Amendment #6:] Nothing in this section shall be construed to require coverage for services provided by a non-participating provider.

4.11.6.15.6.3. [Amendment #6:] The MCO may require prior authorization for covered services only if the MCO has a medical clinician or licensed alcohol and drug counselor available on a 24-hour hotline to make the medical necessity determination and assist with placement at the appropriate level of care, and the MCO provides a prior authorization decision as soon as practicable after receipt from the treating clinician of the clinical rationale consistent with the ASAM criteria, but in no event more than 6 hours of receiving such information; provided that until such hotline determination is made, coverage for substance use disorder services shall be provided at an appropriate level of care consistent with the ASAM criteria, as defined in RSA 420-J:15, I.

4.11.6.15.7 [Amendment #6:] Intentionally left blank. Should the MCO have concerns about the appropriateness of a course of treatment after the treatment has commenced, the MCO shall contact the Provider to request additional information and/or recommend a change, but shall continue to pay for the treatment unless and until the Provider determines an alternative type of treatment or setting is appropriate.

4.11.6.15.8 DHHS shall monitor utilization of Substance Use Disorder treatment services to identify, prevent, and correct potential occurrences of fraud, waste and abuse, in accordance with 42 CFR 455 and 42 CFR 456 and He-W 520.

4.11.6.15.9 DHHS may grant exceptions to this provision in instances where it is necessary to prevent fraud, waste and abuse.

4.11.6.15.10 For Members who enter the Pharmacy Lock-In Program as described in Section 4.2.3 (Clinical Policies and Prior

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Authorizations), the MCO shall evaluate the need for Substance Use Disorder treatment.

4.11.6.16 Opioid Prescribing Requirements

4.11.6.16.1 The MCO shall require Prior Authorization documenting the rationale for the prescriptions of more than one hundred (100) mg daily MED of opioids for Members.

4.11.6.16.2 As required under the NH Board Administrative Rule MED 502 Opioid Prescribing, the MCO shall adhere to MED procedures for acute and chronic pain, taking actions, including but not limited to:

4.11.6.16.2.1. A pain management consultation or certification from the Provider that it is due to an acute medical condition;

4.11.6.16.2.2. Random and periodic UDS; and

4.11.6.16.2.3. Utilizing written, informed consent.

4.11.6.16.3 The MCO shall ensure that Participating Providers prescribe and dispense Naloxone for patients receiving a one hundred (100) mg MED or more per day for longer than ninety (90) calendar days.

4.11.6.16.4 If the NH Board Administrative Rule MED 502 Opioid Prescribing is updated in the future, the MCO shall implement the revised policies in accordance with the timelines established or within sixty (60) calendar days if no such timeline is provided.

4.11.6.17 Neonatal Abstinence Syndrome

4.11.6.17.1 For those Members with a diagnosis of Substance Use Disorder and all infants with a diagnosis of NAS, or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall provide Care Management services to provide for coordination of their physical and behavioral health, according to the safeguards relating to re-disclosure set out in 42 CFR Part 2.

4.11.6.17.2 Substance Use Disorder Care Management features shall include, but not be limited to:

4.11.6.17.2.1. Conducting outreach to Members who would benefit from treatment (for example, by coordinating with emergency room staff to identify and engage with Members admitted to the ED following an overdose),

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4.11.6.17.2.2. Ensuring that Members are receiving the appropriate level of Substance Use Disorder treatment services,

4.11.6.17.2.3. Scheduling Substance Use Disorder treatment appointments and following up to ensure appointments are attended, and

4.11.6.17.2.4. Coordinating care among prescribing Providers, clinician case managers, pharmacists, behavioral health Providers and social service agencies.

4.11.6.17.2.5. The MCO shall make every attempt to coordinate and enhance Care Management services being provided to the Member by the treating Provider.

4.11.6.17.3 The MCO shall work with DCYF to provide Substance Use Disorder treatment referrals and conduct a follow-up after thirty (30) calendar days to determine the outcome of the referral and determine if additional outreach and resources are needed.

4.11.6.17.4 The MCO shall work with DCYF to ensure that health care Providers involved in the care of infants identified as being affected by prenatal drug or alcohol exposure, create and implement the Plan of Safe Care.

4.11.6.17.4.1. The Plan of Safe Care shall be developed in collaboration with health care Providers and the family/caregivers of the infant to address the health of the infant and Substance Use Disorder treatment needs of the family or caregiver.

4.11.6.17.5 The MCO shall establish protocols for Participating Providers to implement a standardized screening and treatment protocol for infants at risk of NAS.

4.11.6.17.6 The MCO shall provide training to Providers serving infants with NAS on best practices, including:

4.11.6.17.6.1. Opportunities for the primary care giver(s) to room-in;

4.11.6.17.6.2. Transportation and childcare for the primary care giver(s);

4.11.6.17.6.3. Priority given to non-pharmaceutical approaches (e.g., quiet environment, swaddling);

4.11.6.17.6.4. Education for primary care giver(s) on caring for newborns;

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4.11.6.17.6.5. Coordination with social service agencies providing supports, including coordinated case meetings and appropriate developmental services for the infant;

4.11.6.17.6.6. Information on family planning options; and

4.11.6.17.6.7. Coordination with the family and Providers on the development of the Plan of Safe Care for any infant born with NAS.

4.11.6.17.7 The MCO shall work with DHHS and Providers eligible to expand/develop services to increase capacity for specialized services for this population which address the family as a unit and are consistent with Northern New England Perinatal Quality Improvement Network's (NNEPQIN) standards.

4.11.6.18 Discharge Planning

4.11.6.18.1 In all cases where the MCO is notified or otherwise learns that a Member has had an ED visit or is hospitalized for an overdose or Substance Use Disorder, the MCO's Care Coordination staff shall actively participate and assist hospital staff in the development of a written discharge plan.

4.11.6.18.2 The MCO shall ensure that the final discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of Members discharged.

4.11.6.18.3 The MCO shall ensure that the discharge progress note shall be provided to any treatment Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.11.6.18.3.1. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.11.6.18.4 It is the expectation of DHHS that Members treated in the ED or inpatient setting for an overdose are not to be released to the community without outreach from the MCO or provided with referrals for an evaluation and treatment.

4.11.6.18.5 The MCO shall track all Members discharged into the community who do not receive MCO contact (including outreach or a referral to a Substance Use Disorder program and/or Provider).

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4.11.6.18.6 The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from the ED to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.11.6.18.7 At least ninety-five percent (95%) of Members discharged shall have been attempted to be contacted within three (3) business days.

4.11.6.18.8 For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the treatment Provider and request that the treatment Provider make contact with the Member within twenty-four (24) hours.

4.11.6.18.9 The MCO shall ensure an appointment for treatment other than evaluation with a Substance Use Disorder program and/or Provider for the Member is scheduled prior to discharge when possible and that transportation has been arranged for the appointment. Such appointments shall occur within seven (7) calendar days after discharge.

4.11.6.18.10 In accordance with 42 CFR Part 2, the MCO shall work with DHHS during regularly scheduled meetings to review cases of Members that have been seen for more than three (3) overdose events within a thirty (30) calendar day period or those that have had a difficulty engaging in treatment services following referral and Care Coordination provided by the MCO.

4.11.6.18.11 The MCO shall also review Member cases with the applicable Substance Use Disorder program and/or Provider to promote strategies for reducing overdoses and increase engagement in treatment services.

4.12 Quality Management

4.12.1 General Provisions

4.12.1.1 The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

4.12.1.2 [Amendment #7:] The MCO shall work in collaboration with DHHS, Members and Providers to actively improve the quality of

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care provided to Members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement.

4.12.1.2.1 [Amendment #7:] The MCO shall conduct reviews and audits of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP), as described in separate guidance.

4.12.1.3 The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate in the MCO's quality improvement activities.

4.12.1.4 The MCO shall support and comply with the most current version of the Quality Strategy for the MCM program.

4.12.1.5 The MCO shall approach all clinical and non-clinical aspects of QAPI based on principles of CQI/Total Quality Management and shall:

4.12.1.5.1 Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

4.12.1.5.2 Foster data-driven decision-making;

4.12.1.5.3 Solicit Member and Provider input on the prioritization and strategies for QAPI activities;

4.12.1.5.4 Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and Member and Provider satisfaction;

4.12.1.5.5 Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

4.12.1.5.6 Support re-measurement of effectiveness, health outcomes improvement and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

4.12.2 Health Plan Accreditation

4.12.2.1 The MCO shall achieve health plan accreditation from the NCQA, including the NCQA Medicaid Module.

4.12.2.2 If the MCO participated in the MCM program prior to the Program Start Date, the MCO shall maintain its health plan accreditation status throughout the period of the Agreement, and

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complete the NCQA Medicaid Module within eighteen (18) months of the Program Start Date.

4.12.2.3 If the MCO is newly participating in the MCM program, the MCO shall achieve health plan accreditation from NCQA, including the Medicaid Module, within eighteen (18) months of the Program Start Date.

4.12.2.4 To demonstrate its progress toward meeting this requirement, the newly participating MCO shall complete the following milestones:

4.12.2.4.1 Within sixty (60) calendar days of the Program Start Date, the MCO shall notify DHHS of the initiation of the process to obtain NCQA Health Plan Accreditation; and

4.12.2.4.2 Within thirty (30) calendar days of the date of the NCQA survey on-site review, the MCO shall notify DHHS of the date of the scheduled on-site review.

4.12.2.5 The MCO shall inform DHHS of whether it has been accredited by any private independent accrediting entity, in addition to NCQA Health Plan Accreditation.

4.12.2.6 The MCO shall authorize NCQA, and any other entity from which it has received or is attempting to receive accreditation, to provide a copy of its most recent accreditation review to DHHS, including [42 CFR 438.332(a)]:

4.12.2.6.1 Accreditation status, survey type, and level (as applicable);

4.12.2.6.2 Accreditation results, including recommended actions or improvements, CAPs, and summaries of findings; and

4.12.2.6.3 Expiration date of the accreditation. [42 CFR 438.332(b)(1)-(3)]

4.12.2.7 To avoid duplication of mandatory activities with accreditation reviews, DHHS may indicate in its quality strategy the accreditation review standards that are comparable to the standards established through federal EQR protocols and that DHHS shall consider met on the basis of the MCO's achievement of NCQA accreditation. [42 CFR 438.360]

4.12.2.8 An MCO going through an NCQA renewal survey shall complete the full Accreditation review of all NCQA Accreditation Standards.

4.12.2.9 During the renewal survey, the MCO shall:

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4.12.2.9.1 Request from NCQA the full review of all NCQA Accreditation Standards and cannot participate in the NCQA renewal survey option that allows attestation for certain requirements; and

4.12.2.9.2 Submit to DHHS a written confirmation from NCQA stating that the renewal survey for the MCO will be for all NCQA Accreditation Standards without attestation.

4.12.3 Quality Assessment and Performance Improvement Program

4.12.3.1 The MCO shall have an ongoing comprehensive QAPI program for the services it furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)].

4.12.3.2 The MCO's QAPI program shall be documented in writing (in the form of the "QAPI Plan"), approved by the MCO's governing body, and submitted to DHHS for its review annually.

4.12.3.3 In accordance with Exhibit O, the QAPI Plan shall contain, at a minimum, the following elements:

4.12.3.3.1 A description of the MCO's organization-wide QAPI program structure;

4.12.3.3.2 The MCO's annual goals and objectives for all quality activities, including but not limited to:

4.12.3.3.2.1. DHHS-required PIPs,

4.12.3.3.2.2. DHHS-required quality performance data,

4.12.3.3.2.3. DHHS-required quality reports, and

4.12.3.3.2.4. Implementation of EQRO recommendations from annual technical reports;

4.12.3.3.3 Mechanisms to detect both underutilization and overutilization of services [42 CFR 438.330(b)(3)];

4.12.3.3.4 Mechanisms to assess the quality and appropriateness of care for Members with Special Health Care Needs (as defined by DHHS in the quality strategy) [42 CFR 438.330(b)(4)] in order to identify any Ongoing Special Conditions of a Member that require a course of treatment or regular care monitoring;

4.12.3.3.5 Mechanisms to assess and address disparities in the quality of, and access to, health care, based on age, race, ethnicity, sex, primary language, and disability status (defined as whether the

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individual qualified for Medicaid on the basis of a disability) [42 CFR 438.340(b)(6)]; and

4.12.3.3.6 The MCO's systematic and ongoing process for monitoring, evaluation and improvement of the quality and appropriateness of Behavioral Health Services provided to Members.

4.12.3.4 The MCO shall maintain a well-defined QAPI program structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the MCO shall ensure that the QAPI program structure:

4.12.3.4.1 Is organization-wide, with clear lines of accountability within the organization;

4.12.3.4.2 Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, clinicians, and non-clinicians;

4.12.3.4.3 Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

4.12.3.4.4 Evaluates the effectiveness of clinical and non-clinical initiatives.

4.12.3.5 If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the MCO shall maintain detailed files documenting work performed by the Subcontractor. The file shall be available for review by DHHS or its designee upon request, and a summary of any functions that have been delegated to Subcontractor(s) shall be indicated within the MCO's QAPI Plan submitted to DHHS annually.

4.12.3.6 Additional detail regarding the elements of the QAPI program and the format in which it should be submitted to DHHS is provided in Exhibit O.

4.12.3.7 Performance Improvement Projects

4.12.3.7.1 The MCO shall conduct any and all PIPs required by CMS. [42 CFR 438.330(a)(2)]

4.12.3.7.2 Amendment #5: Throughout the five-year contract period, Annually, the MCO shall conduct at least three (3) clinical PIPs that meet the following criteria [42 CFR 438.330 (d)(1)]:

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4.12.3.7.2.1. [Amendment #8:] At least one (1) clinical PIP shall have a focus on the Department's objectives outlined in the NH MCM Quality Strategy reducing Psychiatric Boarding in the ED for Medicaid enrollees (regardless of whether they are Medicaid-Medicare dual individuals), as defined in Section 4.11.5 (Mental Health);

4.12.3.7.2.2. At least one (1) clinical PIP shall have a focus on Substance Use Disorder, as defined in Section 4.11.6 (Substance Use Disorder);

4.12.3.7.2.3. At least (1) clinical PIP shall focus on improving quality performance in an area that the MCO performed lower than the fiftieth (50th) percentile nationally, as documented in the most recent EQRO technical report or as otherwise indicated by DHHS.

4.12.3.7.2.4. [Amendment #5:] If the MCO's individual experience is not reflected in the most recent EQRO technical report, the MCO shall incorporate a PIP in an area that the MCOs participating in the MCM program at the time of the most recent EQRO technical report performed below the ~~fiftieth (50th)~~ seventy-fifth (75th) percentile.

4.12.3.7.2.5. [Amendment #5:] Should no quality measure have a lower than ~~fiftieth (50th)~~ seventy-fifth (75th) percentile performance, the MCO shall focus the PIP on one (1) of the areas for which its performance (or, in the event the MCO is not represented in the most recent report, the other MCOs' collective performance) was lowest.

4.12.3.7.3 [Amendment #7:] Throughout the five-year contract ~~Annually~~, the MCO shall conduct at least one (1) non-clinical PIP, which shall be related to one (1) of the following topic areas and approved by DHHS:

4.12.3.7.3.1. Addressing social determinants of health;

4.12.3.7.3.2. Integrating physical and behavioral health.

4.12.3.7.4 The non-clinical PIP may include clinical components, but shall have a primary focus on non-clinical outcomes.

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4.12.3.7.5 The MCO shall ensure that each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction [42 CFR 438.330(d)(2)], and shall include the following elements:

4.12.3.7.5.1. Measurement(s) of performance using objective quality indicators [42 CFR 438.330(d)(2)(i)];

4.12.3.7.5.2. Implementation of interventions to achieve improvement in the access to and quality of care [42 CFR 438.330(d)(2)(ii)];

4.12.3.7.5.3. Evaluation of the effectiveness of the interventions based on the performance measures used as objective quality indicators [42 CFR 438.330(d)(2)(iii)]; and

4.12.3.7.5.4. Planning and initiation of activities for increasing or sustaining improvement [42 CFR 438.330(d)(2)(iv)].

4.12.3.7.6 Each PIP shall be approved by DHHS and shall be completed in a reasonable time period so as to generally permit information on the success of PIPs in the aggregate to produce new information on quality of care every year.

4.12.3.7.7 In accordance with Exhibit O, the MCO shall include in its QAPI Plan, to be submitted to DHHS annually; the status and results of each PIP conducted in the preceding twelve (12) months and any changes it plans to make to PIPs or other MCO processes in the coming years based on these results or other findings [42 CFR 438.330(d)(1) and (3)].

4.12.3.7.8 [Amendment #3:] At the sole discretion of DHHS, the PIPs may be delayed in the event of a public health emergency.

4.12.3.8 Member Experience of Care Survey

4.12.3.8.1 The MCO shall be responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on an annual basis, and as required by NCQA for Medicaid health plan accreditation for both adults and children, including:

4.12.3.8.1.1. CAHPS Health Plan Survey 5.0H, Adult Version or later version as specified by DHHS;

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4.12.3.8.1.2. CAHPS Health Plan Survey 5.0H, Child Version with Children with Chronic Conditions Supplement or later version as specified by DHHS.

4.12.3.8.2 Each CAHPS survey administered by the MCO shall include up to twelve (12) other supplemental questions for each survey as defined by DHHS and indicated in Exhibit O. Supplemental questions, including the number, are subject to NCQA approval.

4.12.3.8.3 The MCO shall obtain DHHS approval of instruments prior to fielding the CAHPS surveys.

4.12.3.9 Quality Measures

4.12.3.9.1 The MCO shall report the following quality measure sets annually according to the current industry/regulatory standard definitions, in accordance with Exhibit O [42 CFR 438.330(b)(2); 42 CFR 438.330(c)(1) and (2); 42 CFR 438.330(a)(2)]:

4.12.3.9.1.1. CMS Child Core Set of Health Care Quality Measures for Medicaid and CHIP, as specified by DHHS;

4.12.3.9.1.2. CMS Adult Core Set of Health Care Quality Measures for Medicaid, as specified by DHHS;

4.12.3.9.1.3. [Amendment #6:] NCQA Medicaid Accreditation measures, including race and ethnicity stratification, which shall be generated without NCQA Allowable Adjustments and validated by submission to NCQA;

4.12.3.9.1.3.1 [Amendment #7] The MCO shall include supplemental data in HEDIS measures identified in Exhibit O for NCQA Accreditation and reporting through Interactive Data Submission System.

4.12.3.9.1.3.2 [Amendment #8:] The MCO shall report Member level data for audited HEDIS measures as identified in Exhibit O.

4.12.3.9.1.4. All available CAHPS measures and sections and additional supplemental questions defined by DHHS;

4.12.3.9.1.5. Any CMS-mandated measures [42 CFR 438.330(c)(1)(i)];

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4.12.3.9.1.6. Select measures to monitor MCO Member and Provider operational quality and Care Coordination efforts;

4.12.3.9.1.7. [Amendment #7:] Select measures specified by DHHS as priority measures for use in assessing and addressing local challenges to high-quality care and access; and

4.12.3.9.1.8. [Amendment #7:] Measures indicated by DHHS as a requirement for fulfilling CMS waiver requirements; and

4.12.3.9.1.9. [Amendment #7] Measures indicated by DHHS as a requirement for the CMS Managed Care Program Annual Report [42 CFR 438.66(e)].

4.12.3.9.2 Consistent with State and federal law, and utilizing all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information, the MCO shall collaborate in data collection with the Integrated Delivery Networks for clinical data collected for quality and performance measures common between the MCM program and the DSRIP program to reduce duplication of effort in collection of data.

4.12.3.9.3 The MCO shall report all quality measures in accordance with Exhibit O, regardless of whether the MCO has achieved accreditation from NCQA.

4.12.3.9.4 The MCO shall submit all quality measures in the formats and schedule in Exhibit O or otherwise identified by DHHS. This includes , as determined by DHHS:

4.12.3.9.4.1. Gain access to and utilize the NH Medicaid Quality Information System, including participating in any DHHS-required training necessary;

4.12.3.9.4.2. Attend all meetings with the relevant MCO subject matter experts to discuss specifications for data indicated in Exhibit O; and

4.12.3.9.4.3. Communicate and distribute all specifications and templates provided by DHHS for measures in Exhibit O to all MCO subject matter experts involved in the production of data in Exhibit O.

4.12.3.9.5 If additional measures are added to the NCQA or CMS measure sets, the MCO shall include any such new measures in its reports to DHHS.

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4.12.3.9.6 For measures that are no longer part of the measure sets, DHHS may, at its option, continue to require those measures; any changes to MCO quality measure reporting requirements shall be communicated to MCOs and documented within a format similar to Exhibit O.

4.12.3.9.7 DHHS shall provide the MCO with ninety (90) calendar days of notice of any additions or modifications to the measures and quality measure specifications.

4.12.3.9.8 At such time as DHHS provides access to Medicare data sets to the MCO, the MCO shall integrate expanded Medicare data sets into its QAPI Plan and Care Coordination and Quality Programs, and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual Members. The MCO shall:

4.12.3.9.8.1. Collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes and psycho-social outcomes resulting from Care Coordination of the dual Members;

4.12.3.9.8.2. Include Medicare data in DHHS quality reporting; and

4.12.3.9.8.3. Sign data use Agreements and submit data management plans, as required by CMS.

4.12.3.9.9 For failure to submit required reports and quality data to DHHS, NCQA, the EQRO, and/or other DHHS-identified entities, the MCO shall be subject to liquidated damages as further described in Section 5.5.2 (Liquidated Damages).

4.12.4 Evaluation

4.12.4.1 DHHS shall, at a minimum, collect the following information, and the information specified throughout the Agreement and within Exhibit O, in order to improve the performance of the MCM program [42 CFR 438.66(c)(6)-(8)]:

4.12.4.1.1 Performance on required quality measures; and

4.12.4.1.2 The MCO's QAPI Plan.

4.12.4.2 Starting in the second year of the Term of this Agreement, the MCO shall include in its QAPI Plan a detailed report of the MCO's performance against its QAPI Plan throughout the duration of the

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preceding twelve (12) months, and how its development of the proposed, updated QAPI plan has taken those results into account. The report shall include detailed information related to:

4.12.4.2.1 Completed and ongoing quality management activities, including all delegated functions;

4.12.4.2.2 Performance trends on QAPI measures to assess performance in quality of care and quality of service (QOS) for all activities identified in the QAPI Plan;

4.12.4.2.3 An analysis of whether there have been any demonstrated improvements in the quality of care or service for all activities identified in the QAPI Plan;

4.12.4.2.4 An analysis of actions taken by the MCO based on MCO specific recommendations identified by the EQRO's Technical Report and other Quality Studies; and

4.12.4.2.5 An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement.

4.12.4.3 The annual evaluation report, developed in accordance with Exhibit O, shall be reviewed and approved by the MCO's governing body and submitted to DHHS for review [42 CFR 438.330(e)(2)].

4.12.4.4 The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, Members, and appropriate MCO staff, as well as for posting on the web.

4.12.4.5 In accordance with Exhibit O, the MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to DHHS and reviewed by the appropriate individuals within the organization.

4.12.5 Accountability for Quality Improvement

4.12.5.1 External Quality Review

4.12.5.1.1 The MCO shall collaborate and cooperate fully with DHHS's EQRO in the conducting of CMS EQR activities to identify opportunities for MCO improvement [42 CFR 438.358].

4.12.5.1.2 Annually, the MCO shall undergo external independent reviews of the quality, timeliness, and access to services for Members [42 CFR 438.350].

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4.12.5.1.3 To facilitate this process, the MCO shall supply information, including but not limited to:

- 4.12.5.1.3.1. Claims data,
- 4.12.5.1.3.2. Medical records,
- 4.12.5.1.3.3. Operational process details, and
- 4.12.5.1.3.4. Source code used to calculate performance measures to the EQRO as specified by DHHS.

4.12.5.2 Auto-Assignment Algorithm

4.12.5.2.1 As indicated in Section 4.3.6 (Auto-Assignment), the auto-assignment algorithm shall, over time, reward high-performing MCOs that offer high-quality, accessible care to its Members.

4.12.5.2.2 [Amendment #5:] The measures used to determine auto-assignment ~~shall not be limited to alignment shall be aligned~~ with the priority measures assigned to the program MCM Withhold and Incentive Program MCO withhold program, as determined by DHHS.

4.12.5.3 Quality Performance Withhold

4.12.5.3.1 [Amendment #5:] As described in Section 5.4 (MCM Withhold and Incentive Program), the MCM program incorporates a withhold and incentive arrangement; the MCO's performance in the program may be assessed on the basis of the MCO's quality performance, as determined by DHHS and indicated to the MCO in ~~annual~~ periodic guidance.

4.12.5.3.2 [Amendment #5:] Intentionally left blank. ~~Key areas of DHHS focus in the selection of measures shall include, but are not limited to:~~

4.12.5.3.2.1. [Amendment #5:] Intentionally left blank. ~~Utilization measures, including appropriate use of the ED, reduction in preventable admissions, and/or 30-day hospital readmission for all causes;~~

4.12.5.3.2.2. [Amendment #5:] Intentionally left blank. ~~Measures related to the timeliness of prenatal and postpartum care and in improved outcomes related to NAS births;~~

4.12.5.3.2.3. [Amendment #5:] Intentionally left blank. ~~Successful integration of physical and behavioral health,~~

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~~including timeliness of a follow up after a mental illness or Substance Use Disorder inpatient or residential admission;~~

4.12.5.3.2.4. [Amendment #5:] Intentionally left blank.
~~Reduction in polypharmacy resulting in drug interaction harm; and~~

4.12.5.3.2.5. [Amendment #5:] Intentionally left blank.
~~Certain clinical and non-clinical quality measures for which there is ample opportunity for improved MCO performance.~~

4.13 Network Management

4.13.1 Network Requirements

4.13.1.1 The MCO shall maintain and monitor a network of appropriate Participating Providers that is:

4.13.1.1.1 Supported by written agreements; and

4.13.1.1.2 Sufficient to provide adequate access to all services covered under this Agreement for all Members, including those with LEP or disabilities. [42 CFR 438.206(b)(1)]

4.13.1.2 In developing its network, the MCO's Provider selection policies and procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

4.13.1.3 [Amendment #8:] The MCO shall not employ or contract with Providers excluded from participation in federal health care programs [42 CFR 438.214(d)(1)]; 42 CFR 455.101; Section 1932(d)(5) of the Act.

4.13.1.4 The MCO shall not employ or contract with Providers who fail to provide Equal Access to services.

4.13.1.5 The MCO shall ensure its Participating Providers and Subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement. [42 CFR 438.230]

4.13.1.6 All Participating Providers shall be licensed and or certified in accordance with the laws of NH and not be under sanction or exclusion from any Medicare or Medicaid program. Participating Providers shall have a NH Medicaid identification number and unique

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National Provider Identifier (NPI) for every Provider type in accordance with 45 CFR 162, Subpart D.

4.13.1.7 The MCO shall provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Medical Conditions.

4.13.1.8 The MCO shall make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Agreement can be furnished promptly and without compromising the quality of care. [42 CFR 438.3(q)(1); 42 CFR 438.3(q)(3)]

4.13.1.9 The MCO shall permit Non-Participating IHCPs to refer an American Indian/Alaskan Native Member to a Participating Provider. [42 CFR 438.14(b)(6)]

4.13.1.10 The MCO shall implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Participating Providers were received by Members and the application of such verification processes on a regular basis. [42 CFR 438.608(a)(5)]

4.13.1.11 Amendment #4: When contracting with DME Providers, the MCO shall contract with and have in its network all Willing Providers in the state.

4.13.2 Provider Enrollment

4.13.2.1 The MCO shall ensure that its Participating Providers are enrolled with NH Medicaid.

4.13.2.2 The MCO shall prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by DHHS for determination of the MCO's network adequacy.

4.13.2.2.1 The report shall identify fully credentialed and contracted Providers, and prospective Participating Providers.

4.13.2.2.2 Prospective Participating Providers shall have executed letters of intent to contract with the MCO.

4.13.2.2.3 The MCO shall confirm its provider-network with DHHS and post to its website no later than thirty (30) calendar days prior to the Member enrollment period.

4.13.2.3 The MCO shall not discriminate relative to the participation, reimbursement, or indemnification of any Provider who

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is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

4.13.2.4 If the MCO declines to include individual Provider or Provider groups in its network, the MCO shall give the affected Providers written notice of the reason for its decision. [42 CFR 438.12(a)(1); 42 CFR 438.214(c)]

4.13.2.5 The requirements in 42 CFR 438.12(a) shall not be construed to:

4.13.2.5.1 Require the MCO to contract with Providers beyond the number necessary to meet the needs of its Members;

4.13.2.5.2 Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

4.13.2.5.3 Preclude the MCO from establishing measures that are designed to maintain QOS and control costs and is consistent with its responsibilities to Members. [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)-(3)]

4.13.2.6 The MCO shall ensure that Participating Providers are enrolled with DHHS Medicaid as Medicaid Providers consistent with Provider disclosure, screening and enrollment requirements. [42 CFR 438.608(b); 42 CFR 455.100-106; 42 CFR 455.400 – 470]

4.13.3 Provider Screening, Credentialing and Re-Credentialing

4.13.3.1 DHHS shall screen and enroll, and periodically revalidate all MCO Participating Providers as Medicaid Providers. [42 CFR 438.602(b)(1)].

4.13.3.2 The MCO shall rely on DHHS's NH Medicaid providers' affirmative screening in accordance with federal requirements and the current NCQA Standards and Guidelines for the credentialing and re-credentialing of licensed independent Providers and Provider groups with whom it contracts or employs and who fall within its scope of authority and action. [42 CFR 455.410; 42 CFR 438.206)(b)(6)]

4.13.3.3 The MCO shall utilize a universal provider datasource, at no charge to the provider, to reduce administrative requirements and streamline data collection during the credentialing and re-credentialing process.

4.13.3.4 The MCO shall demonstrate that its Participating Providers are credentialed, and shall comply with any additional Provider selection requirements established by DHHS. [42 CFR

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438.12(a)(2); 42 CFR 438.214(b)(1); 42 CFR 438.214(c); 42 CFR 438.214(e); 42 CFR 438.206(b)(6)]

4.13.3.5 The MCO's Provider selection policies and procedures shall include a documented process for credentialing and re-credentialing Providers who have signed contracts with the MCO. [42 CFR 438.214(b)]

4.13.3.6 The MCO shall submit for DHHS review during the Readiness Review period, policies and procedures for onboarding Participating Providers, which shall include its subcontracted entity's policies and procedures.

4.13.3.7 For Providers not currently enrolled with NH Medicaid, the MCO shall:

4.13.3.7.1 Make reasonable efforts to streamline the credentialing process in collaboration with DHHS;

4.13.3.7.2 Conduct outreach to prospective Participating Providers within ten (10) business days after the MCO receives notice of the Providers' desire to enroll with the MCO;

4.13.3.7.3 Concurrently work through MCO and DHHS contracting and credentialing processes with Providers in an effort to expedite the Providers' network status; and

4.13.3.7.4 Educate prospective Participating Providers on optional Member treatment and payment options while credentialing is underway, including:

4.13.3.7.4.1. Authorization of out-of-network services;

4.13.3.7.4.2. Single case agreements for an individual Member; and

4.13.3.7.4.3. If agreed upon by the prospective Participating Provider, an opportunity for the Provider to accept a level of risk to receive payment after affirmative credentialing is completed in exchange for the prospective Participating Provider's compliance with network requirements and practices.

4.13.3.8 The MCO shall process credentialing applications from all types of Providers within prescribed timeframes as follows:

4.13.3.8.1 For PCPs, within thirty (30) calendar days of receipt of clean and complete credentialing applications; and

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4.13.3.8.2 For specialty care Providers, within forty-five (45) calendar days of receipt of clean and complete credentialing applications;

4.13.3.8.3 For any Provider submitting new or missing information for its credentialing application, the MCO shall act upon the new or updated information within ten (10) business days.

4.13.3.9 The start time for the approval process begins when the MCO has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status.

4.13.3.10 A "clean and complete" application is an application that is signed and appropriately dated by the Provider, and includes:

4.13.3.10.1 Evidence of the Provider's NH Medicaid ID; and

4.13.3.10.2 Other applicable information to support the Provider application, including Provider explanations related to quality and clinical competence satisfactory to the MCO.

4.13.3.11 In the event the MCO does not process a Provider's clean and complete credentialing application within the timeframes set forth in this Section, 4.13.3 of the Agreement, the MCO shall pay the Provider retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application, depending on the prescribed timeframe for the Provider type as defined in 4.13.3.8 above.

4.13.3.12 For each day a clean and complete application is delayed beyond the prescribed timeframes in this Agreement as determined by periodic audit of the MCO's Provider enrollment records by DHHS or its designee, the MCO shall be fined in accordance with Exhibit N (Liquidated Damages Matrix).

4.13.3.13 Nothing in this Agreement shall be construed to require the MCO to select a health care professional as a Participating Provider solely because the health care professional meets the NH Medicaid screening and credentialing verification standards, or to prevent an MCO from utilizing additional criteria in selecting the health care professionals with whom it contracts.

4.13.4 Provider Engagement

4.13.4.1 Provider Support Services

4.13.4.1.1 The MCO shall develop and make available Provider support services which include, at a minimum:

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4.13.4.1.1.1. A website with information and a dedicated contact number to assist and support Providers who are interested in becoming Participating Providers;

4.13.4.1.1.2. A dedicated contact number to MCO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday and 9:00 a.m. to 12:00 p.m. on Saturday for the purposes of answering questions related to contracting, billing and service provision.

4.13.4.1.1.3. Ability for Providers to contact the MCO regarding contracting, billing, and service provisions;

4.13.4.1.1.4. Training specific to integration of physical and behavioral health, person-centered Care Management, social determinants of health, and quality;

4.13.4.1.1.5. Training curriculum, to be developed, in coordination with DHHS, that addresses clinical components necessary to meet the needs of Children with Special Health Care Needs. Examples of clinical topics shall include: federal requirements for EPSDT; unique needs of Children with Special Health Care Needs; family-driven, youth-guided, person-centered treatment planning and service provisions; impact of adverse childhood experiences; utilization of evidence-based practices; trauma-informed care; Recovery and resilience principles; and the value of person-centered Care Management that includes meaningful engagement of families/caregivers;

4.13.4.1.1.6. Training on billing and required documentation;

4.13.4.1.1.7. Assistance and/or guidance on identified opportunities for quality improvement;

4.13.4.1.1.8. Training to Providers in supporting and assisting Members in grievances and appeals, as noted in Section 4.5.1 (General Requirements); and

4.13.4.1.1.9. Training to Providers in MCO claims submittal through the MCO Provider portal.

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4.13.4.1.2 The MCO shall establish and maintain a Provider services function to respond timely and adequately to Provider questions, comments, and inquiries.

4.13.4.1.3 As part of this function, the MCO shall operate a toll-free telephone line (Provider service line) from, at minimum, eight (8:00) am to five (5:00) pm EST, Monday through Friday, with the exception of DHHS-approved holidays. The Provider call center shall meet the following minimum standards, which may be modified by DHHS as necessary:

4.13.4.1.3.1. Call abandonment rate: fewer than five percent (5%) of all calls shall be abandoned;

4.13.4.1.3.2. Average speed of answer: eighty percent (80%) of all calls shall be answered with live voice within thirty (30) seconds;

4.13.4.1.3.3. Average speed of voicemail response: ninety percent (90%) of voicemail messages shall be responded to no later than the next business day (defined as Monday through Friday, with the exception of DHHS-approved holidays).

4.13.4.1.4 The MCO shall ensure that, after regular business hours, the Provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a Member.

4.13.4.1.5 The MCO shall have a process in place to handle after-hours inquiries from Providers seeking a service authorization for a Member with an urgent or emergency medical or behavioral health condition.

4.13.4.1.6 The MCO shall track the use of State-selected and nationally recognized clinical Practice Guidelines for Children with Special Health Care Needs.

4.13.4.1.7 DHHS may provide additional guidelines to MCOs pertaining to evidence-based practices related to the following: Trauma-Focused Cognitive Behavioral Therapy; Trauma Informed Child-Parent Psychotherapy; Multi-systemic Therapy; Functional Family Therapy; Multi-Dimensional Treatment Foster Care; DBT; Multidimensional Family Therapy; Adolescent Community Reinforcement; and Assertive Continuing Care.

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4.13.4.1.8 The MCO shall track and trend Provider inquiries, complaints and requests for information and take systemic action as necessary and appropriate pursuant to Exhibit O.

4.13.4.2 Provider Advisory Board

4.13.4.2.1 [Amendment #8:] The MCO shall develop and facilitate an active Provider Advisory Board that is composed of a broad spectrum of Provider types. Provider representation on the Provider Advisory Board shall draw from and be reflective of Member needs and should ensure accurate and timely feedback on the MCM program, and shall include representation from at least one (1) FQHC, at least one (1) CMH Program, and at least one (1) Local Care Management Network provider, as applicable. ~~Integrated Delivery Network (IDN).~~

4.13.4.2.2 The Provider Advisory Board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the Provider Advisory Board meetings shall be provided to DHHS upon request.

4.13.5 Provider Contract Requirements

4.13.5.1 General Provisions

4.13.5.1.1 The MCO's agreement with health care Providers shall:

4.13.5.1.1.1. Be in writing,

4.13.5.1.1.2. Be in compliance with applicable State and federal laws and regulations, and

4.13.5.1.1.3. Include the requirements in this Agreement.

4.13.5.1.2 The MCO shall submit all model Provider contracts to DHHS for review before execution of the Provider contracts with NH Medicaid Providers.

4.13.5.1.3 The MCO shall re-submit the model Provider contracts any time it makes substantive modifications.

4.13.5.1.4 DHHS retains the right to reject or require changes to any Provider contract.

4.13.5.1.5 In all contracts with Participating Providers, the MCO shall comply with requirements in 42 CFR 438.214 and RSA 420-J:4, which includes selection and retention of Participating Providers, credentialing and re-credentialing requirements, and non-discrimination.

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4.13.5.1.6 In all contracts with Participating Providers, the MCO shall follow a documented process for credentialing and re-credentialing of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(b)(2)]

4.13.5.1.7 The MCO's Participating Providers shall not discriminate against eligible Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, the ADA of 1990, 42 U.S.C. Section 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

4.13.5.1.8 The MCO shall require Participating Providers and Subcontractors to not discriminate against eligible persons or Members on the basis of their health or behavioral health history, health or behavioral health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4.13.5.1.9 The MCO shall keep participating physicians and other Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

4.13.5.1.10 The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.14 (Alternative Payment Models).

4.13.5.1.11 The MCO may execute Participating Provider agreements, pending the outcome of screening and enrollment in NH Medicaid, of up to one hundred and twenty (120) calendar days duration but shall terminate a Participating Provider immediately upon notification from DHHS that the Participating Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without enrollment of the Provider, and notify affected Members. [42 CFR 438.602(b)(2)]

4.13.5.1.12 The MCO shall maintain a Provider relations presence in NH, as approved by DHHS.

4.13.5.1.13 The MCO shall prepare and issue Provider Manual(s) upon request to all newly contracted and credentialed Providers and

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all Participating Providers, including any necessary specialty manuals (e.g., behavioral health).

4.13.5.1.13.1. The Provider manual shall be available and easily accessible on the web and updated no less than annually.

4.13.5.1.14 The MCO shall provide training to all Participating Providers and their staff regarding the requirements of this Agreement, including the grievance and appeal system.

4.13.5.1.14.1. The MCO's Provider training shall be completed within thirty (30) calendar days of entering into a contract with a Provider.

4.13.5.1.14.2. The MCO shall provide ongoing training to new and existing Providers as required by the MCO, or as required by DHHS.

4.13.5.1.15 Provider materials shall comply with State and federal laws and DHHS and NHID requirements.

4.13.5.1.16 The MCO shall submit any Provider Manual(s) and Provider training materials to DHHS for review during the Readiness Review period and sixty (60) calendar days prior to any substantive revisions.

4.13.5.1.17 Any revisions required by DHHS shall be provided to the MCO within thirty (30) calendar days.

4.13.5.1.18 The MCO Provider Manual shall consist of, at a minimum:

4.13.5.1.18.1. A description of the MCO's enrollment and credentialing process;

4.13.5.1.18.2. How to access MCO Provider relations assistance;

4.13.5.1.18.3. A description of the MCO's medical management and Case Management programs;

4.13.5.1.18.4. Detail on the MCO's Prior Authorization processes;

4.13.5.1.18.5. A description of the Covered Services and Benefits for Members, including EPSDT and pharmacy;

4.13.5.1.18.6. A description of Emergency Services coverage;

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4.13.5.1.18.7. Member parity;

4.13.5.1.18.8. The MCO Payment policies and processes; and

4.13.5.1.18.9. The MCO Member and Provider Grievance System.

4.13.5.1.19 The MCO shall require that Providers not bill Members for Covered Services any amount greater than the Medicaid cost-sharing owed by the Member (i.e., no balance billing by Providers). [Section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230(c)(1)-(2)]

4.13.5.1.20 In all contracts with Participating Providers, the MCO shall require Participating Providers to remain neutral when assisting potential Members and Members with enrollment decisions.

4.13.5.2 Compliance with MCO Policies and Procedures

4.13.5.2.1 The MCO shall require Participating Providers to comply with all MCO policies and procedures, including without limitation:

4.13.5.2.1.1. The MCO's DRA policy;

4.13.5.2.1.2. The Provider Manual;

4.13.5.2.1.3. The MCO's Compliance Program;

4.13.5.2.1.4. The MCO's Grievance and Appeals and Provider Appeal Processes;

4.13.5.2.1.5. Clean Claims and Prompt Payment requirements;

4.13.5.2.1.6. ADA requirements;

4.13.5.2.1.7. Clinical Practice Guidelines; and

4.13.5.2.1.8. Prior Authorization requirements.

4.13.5.3 The MCO shall inform Participating Providers, at the time they enter into a contract with the MCO, about the following requirements, as described in Section 4.5 (Member Grievances and Appeals), of:

4.13.5.3.1 Member grievance, appeal, and fair hearing procedures and timeframes;

4.13.5.3.2 The Member's right to file grievances and appeals and the requirements and timeframe for filing;

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4.13.5.3.3 The availability of assistance to the Member with filing grievances and appeals; [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(A)-(C)]

4.13.5.3.4 The Member's right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)]

4.13.5.3.5 The Member's right to request continuation of benefits that the MCO seeks to reduce or terminate during an appeal of State fair hearing filing, if filed within the permissible timeframes, although the Member may be liable for the cost of any continued benefits while the appeal or State fair hearing is pending if the final decision is adverse to the Member. [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(E)]

4.13.5.4 Member Hold Harmless

4.13.5.4.1 The Provider shall agree to hold the Member harmless for the costs of Medically Necessary Covered Services except for applicable cost sharing and patient liability amounts indicated by DHHS in this Agreement [RSA 420-J:8.I.(a)]

4.13.5.5 Requirement to Return Overpayment

4.13.5.5.1 The Provider shall comply with the Affordable Care Act and the MCO's policies and procedures that require the Provider to report and return any Overpayments identified within sixty (60) calendar days from the date the Overpayment is identified, and to notify the MCO in writing of the reason for the Overpayment. [42 CFR 438.608(d)(2)]

4.13.5.5.2 Overpayments that are not returned within sixty (60) calendar days from the date the Overpayment was identified may be a violation of State or federal law.

4.13.5.6 Background Screening

4.13.5.6.1 The Provider shall screen its staff prior to contracting with the MCO and monthly thereafter against the Exclusion Lists.

4.13.5.6.1.1. In the event the Provider identifies that any of its staff is listed on any of the Exclusion Lists, the Provider shall notify the MCO within three (3) business days of learning of that such staff Member is listed on any of the Exclusion Lists and immediately remove such person from providing services under the agreement with the MCO.

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4.13.5.7 Books and Records Access

4.13.5.7.1 The Provider shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the Members as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements.

4.13.5.7.2 The Provider shall make available, for the purposes of an audit, evaluation, or inspection by the MCO, DHHS, MFCU, DOJ, the OIG, and the Comptroller General or their respective designees:

4.13.5.7.3 Its premises,

4.13.5.7.4 Physical facilities,

4.13.5.7.5 Equipment,

4.13.5.7.6 Books,

4.13.5.7.7 Records,

4.13.5.7.8 Contracts, and

4.13.5.7.9 Computer, or other electronic systems relating to its Medicaid Members.

4.13.5.7.10 These records, books, documents, etc., shall be available for any authorized State or federal agency, including but not limited to the MCO, DHHS, MFCU, DOJ, and the OIG or their respective designees, ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

4.13.5.8 Continuity of Care

4.13.5.8.1 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth by DHHS and included in the DHHS model Member Handbook.

4.13.5.9 Anti-Gag Clause

4.13.5.9.1 The MCO shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient:

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4.13.5.9.1.1. For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

4.13.5.9.1.2. For any information the Member needs in order to decide among all relevant treatment options;

4.13.5.9.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

4.13.5.9.1.4. For the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. [Section 1923(b)(3)(D) of the Social Security Act; 42 CFR 438.102(a)(1)(i)-(iv); SMDL 2/20/98]

4.13.5.9.2 The MCO shall not take punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, consistent with the requirements in Section 4.5.5 (Expedited Appeal). [42 CFR 438.410(b)]

4.13.5.10 Anti-Discrimination

4.13.5.10.1 The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification or against any Provider that serves high-risk populations or specializes in conditions that require costly treatment.

4.13.5.10.2 This paragraph shall not be construed to prohibit an organization from:

4.13.5.10.2.1. Including Providers only to the extent necessary to meet the needs of the organization's Members,

4.13.5.10.2.2. Establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or

4.13.5.10.2.3. Using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

4.13.5.10.3 If the MCO declines to include individual or groups of Providers in its network, it shall give the affected Providers written notice of the reason for the decision.

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4.13.5.10.4 In all contracts with Participating Providers, the MCO's Provider selection policies and procedures shall not discriminate against particular Providers that service high-risk populations or specialize in conditions that require costly treatment. [42 CFR 438.12(a)(2); 42 CFR 438.214(c)]

4.13.5.11 Access and Availability

4.13.5.11.1 The MCO shall ensure that Providers comply with the time and distance and wait standards, including but not limited to those described in Section 4.7.3 (Time and Distance Standards) and Section 4.7.3.4 (Additional Provider Standards).

4.13.5.12 Payment Models

4.13.5.12.1 The MCO shall negotiate rates with Providers in accordance with Section 4.14 (Alternative Payment Models) and Section 4.15 (Provider Payments) of this Agreement, unless otherwise specified by DHHS (e.g., for Substance Use Disorder Provider rates).

4.13.5.12.2 The MCO Provider contract shall contain full and timely disclosure of the method and amount of compensation, payments, or other consideration, to be made to and received by the Provider from the MCO, including for Providers paid by an MCO Subcontractor, such as the PBM.

4.13.5.12.3 The MCO Provider contract shall detail how the MCO shall meet its reporting obligations to Providers as described within this Agreement.

4.13.5.13 Non-Exclusivity

4.13.5.13.1 The MCO shall not require a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

4.13.5.14 Proof of Membership

4.13.5.14.1 The MCO Provider contract shall require Providers in the MCO network to accept the Member's Medicaid identification card as proof of enrollment in the MCO until the Member receives his/her MCO identification card.

4.13.5.15 Other Provisions

4.13.5.15.1 The MCO's Provider contract shall also contain:

4.13.5.15.1.1. All required activities and obligations of the Provider and related reporting responsibilities.

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4.13.5.15.1.2. Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement.

4.13.5.15.1.3. A requirement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority.

4.13.6 Reporting

4.13.6.1 The MCO shall comply with and complete all reporting in accordance with Exhibit O, this Agreement, and as further specified by DHHS.

4.13.6.2 The MCO shall implement and maintain arrangements or procedures for notification to DHHS when it receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the managed care program, including the termination of the Provider agreement with the MCO. [42 CFR 438.608(a)(4)]

4.13.6.3 The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the Participating Provider network.

4.13.6.4 As part of the notice, the MCO shall submit a Transition Plan to DHHS to address continued Member access to needed service and how the MCO shall maintain compliance with its contractual obligations for Member access to needed services.

4.13.6.5 A significant change is defined as:

4.13.6.5.1 A decrease in the total number of PCPs by more than five percent (5%);

4.13.6.5.2 A loss of all Providers in a specific specialty where another Provider in that specialty is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement;

4.13.6.5.3 A loss of a hospital in an area where another contracted hospital of equal service ability is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement; and/or

4.13.6.5.4 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to Participating Providers.

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4.13.6.6 The MCO shall provide to DHHS and/or its DHHS Subcontractors (e.g., the EQRO) Provider participation reports on an annual basis or as otherwise determined by DHHS in accordance with Exhibit O; these may include but are not limited to Provider participation by geographic location, categories of service, Provider type categories, Providers with open panels, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze Provider service capacity in terms of Member access to health care.

4.14 Alternative Payment Models

4.14.1 As required by the special terms and conditions of The NH Building Capacity for Transformation waiver, NH is implementing a strategy to expand use of APMs that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to DHHS, Providers, and the stakeholder community.

4.14.2 In developing and refining its APM strategy, DHHS relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the "HCP-LAN APM framework") in order to:

4.14.2.1 Clearly and effectively communicate DHHS requirements through use of the defined categories established by HCP-LAN;

4.14.2.2 Encourage the MCO to align MCM APM offerings to other payers' APM initiatives to minimize Provider burden; and

4.14.2.3 Provide an established framework for monitoring MCO performance on APMs.

4.14.3 Prior to and/or over the course of the Term of this Agreement, DHHS shall develop the DHHS Medicaid APM Strategy, which may result in additional guidance, templates, worksheets and other materials that elucidate the requirements to which the MCO is subject under this Agreement.

4.14.4 Within the guidance parameters established and issued by DHHS and subject to DHHS approval, the MCO shall have flexibility to design Qualifying APMs (as defined in Section 4.14 of this Agreement) consistent with the DHHS Medicaid APM strategy and in conformance with CMS guidance.

4.14.5 The MCO shall support DHHS in developing the DHHS Medicaid APM Strategy through participation in stakeholder meetings and planning efforts, providing all required and otherwise requested information related to APMs, sharing data and analysis, and other activities as specified by DHHS.

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4.14.6 For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and DHHS shall ensure that it:

4.14.6.1 Makes participation in the APM available, using the same terms of performance, to a class of Providers providing services under the contract related to the reform or improvement initiative;

4.14.6.2 Uses a common set of performance measures across all the Providers;

4.14.6.3 Does not set the amount or frequency of the expenditures; and

4.14.6.4 Does not permit DHHS to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

4.14.7 Required Use of Alternative Payment Models Consistent with the New Hampshire Building Capacity for Transformation Waiver

4.14.7.1 Consistent with the requirements set forth in the special terms and conditions of NH's Building Capacity for Transformation waiver, the MCO shall ensure through its APM Implementation Plan (as described in Section 4.14) that fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs, as defined by DHHS, within the first twelve (12) months of this Agreement, subject to the following exceptions:

4.14.7.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have eighteen (18) months to meet this requirement; and

4.14.7.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS.

4.14.7.1.2.1. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6) months after the initial 18 month period.

4.14.7.1.2.2. For failure to meet this requirement, DHHS reserves to right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N, Section 3.2 (Liquidated Damages Matrix).

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4.14.7.2 MCO Incentives and Penalties for APM Implementation

4.14.7.2.1 Consistent with RSA 126-AA, the MCO shall include, through APMs and other means, Provider alignment incentives to leverage the combined DHHS, MCO, and providers to achieve the purpose of the incentives.

4.14.7.2.2 MCOs shall be subject to incentives, at DHHS' sole discretion, and/or penalties to achieve improved performance, including preferential auto-assignment of new members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

4.14.8 Qualifying Alternative Payment Models

4.14.8.1 A Qualifying APM is a payment approach approved by DHHS as consistent with the standards specified in this Section 4.14.8 (Qualifying Alternative Payment Models) and the DHHS Medicaid APM Strategy.

4.14.8.2 [Amendment #5:] At minimum, a Qualifying APM shall meet the requirements of the HCP-LAN APM framework Category 2B 2G, based on the refreshed 2017 framework released on July 11, 2017 and all subsequent revisions.

4.14.8.3 [Amendment #5:] As indicated in the HCP-LAN APM framework white paper, Category 2B 2G is met if the payment arrangement between the MCO and Participating Provider(s) rewards Participating Providers at a minimum for reporting quality metrics. that perform well on quality metrics and/or penalizes Participating Providers that do not perform well on those metrics.

4.14.8.4 [Amendment #5:] HCP-LAN Categories 2B, 3A, 3B, 4A, 4B, and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy.

4.14.8.5 DHHS shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.14.10.2 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to DHHS, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.

4.14.8.6 Under no circumstances shall DHHS consider a payment methodology that takes cost of care into account without also considering quality a Qualifying APM.

4.14.8.7 Standards for Large Providers and Provider Systems

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4.14.8.7.1 The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the DHHS Medicaid APM Strategy.

4.14.8.8 Treatment of Payments to Community Mental Health Programs

4.14.8.8.1 The CMH Program payment model prescribed by DHHS in Section 4.11.5.1 (Contracting for Community Mental Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.8.2 At the sole discretion of DHHS, additional payment models specifically required by and defined as an APM by DHHS shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.9 [Amendment #5:] Accommodations for Other Providers ~~Small Providers~~

4.14.8.9.1 [Amendment #5:] The MCO ~~may shall~~ develop Qualifying APM models appropriate for small Providers, and/or Federally Qualified Health Centers (FQHCs), as further defined by the DHHS Medicaid APM Strategy.

4.14.8.9.2 For example, the MCO may propose to DHHS models that incorporate pay-for-performance bonus incentives and/or per Member per month payments related to Providers' success in meeting actuarially-relevant cost and quality targets.

4.14.8.10 Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health

4.14.8.10.1 The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden and promote the integration of Behavioral Health.

4.14.8.10.2 [Amendment #5:] The MCO ~~shall may~~ incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Payer Advanced APM" (including but not limited to a Medicaid Medical Home Model) under the requirements of the Quality Payment Program as set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

4.14.9 MCO Alternative Payment Model Implementation Plan

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4.14.9.1 The MCO shall submit to DHHS for review and approval an APM Implementation Plan in accordance with Exhibit O.

4.14.9.2 The APM Implementation Plan shall meet the requirements of this section and of any subsequent guidance issued as part of the DHHS Medicaid APM Strategy.

4.14.9.3 Additional details on the timing, format, and required contents of the MCO APM Implementation Plan shall be specified by DHHS in Exhibit O and/or through additional guidance.

4.14.9.4 Alternative Payment Model Transparency

4.14.9.4.1 The MCO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the MCO's methodology, as well as the basis for developing and assessing Participating Provider performance in the APM, as described in Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how integration is promoted by the model among the MCO, Providers, and Members.

4.14.9.5 Provider Engagement and Support

4.14.9.5.1 The APM Implementation Plan shall describe a logical and reasonably achievable approach to implementing APMs, supported by an understanding of NH Medicaid Providers' readiness for participation in APMs, and the strategies the MCO shall use to assess and advance such readiness over time.

4.14.9.5.2 The APM Implementation Plan shall outline in detail what strategies the MCO plans to use, such as, meetings with Providers and IDNs, as appropriate, and the frequency of such meetings, the provision of technical support, and a data sharing strategy for Providers reflecting the transparency, reporting and data sharing obligations herein and in the DHHS Medicaid APM Strategy.

4.14.9.5.3 The MCO APM Implementation Plan shall ensure Providers and IDNs, as appropriate, are supported by data sharing and performance analytic feedback systems and tools that make actuarially sound and actionable provider level and system level clinical, cost, and performance data available to Providers in a timely manner for purposes of developing APMs and analyzing performance and payments pursuant to APMs.

4.14.9.5.4 MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

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4.14.9.6 Implementation Approach

4.14.9.6.1 The MCO shall include in the APM Implementation Plan a detailed description of the steps the MCO shall take to advance its APM Implementation Plan:

4.14.9.6.1.1. In advance of the Program Start Date;

4.14.9.6.1.2. During the first year of this Agreement;
and

4.14.9.6.1.3. Into the second year and beyond,
clearly articulating its long-term vision and goals for the
advancement of APMs over time.

4.14.9.6.2 The APM Implementation Plan shall include the MCO's plan for providing the necessary data and information to participating APM Providers to ensure Providers' ability to successfully implement and meet the performance expectations included in the APM, including how the MCO shall ensure that the information received by Participating Providers is meaningful and actionable.

4.14.9.6.3 The MCO shall provide data to Providers and IDNs, as appropriate, that describe the retrospective cost and utilization patterns for Members, which shall inform the strategy and design of APMs.

4.14.9.6.4 For each APM entered into, the MCO shall provide timely and actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM.

4.14.9.6.5 In addition, the MCO shall provide Member and Provider level data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions.

4.14.9.6.6 The APM Implementation Plan shall describe in example form to DHHS the level of information that shall be given to Providers that enter into APM Agreements with the MCO, including if the level of information shall vary based on the Category and/or type of APM the Provider enters.

4.14.9.6.7 The information provided shall be consistent with the requirements outlined under Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The MCOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

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4.14.10 Alternative Payment Model Transparency and Reporting Requirements

4.14.10.1 Transparency

4.14.10.1.1 In the MCO APM Implementation Plan, the MCO shall provide to DHHS for each APM, as applicable, the following information at a minimum:

4.14.10.1.1.1. The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.14.10.1.1.2. The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, the attachment points for cost targets, and risk adjustment methodology;

4.14.10.1.1.3. The approach to determining quality benchmarks and evaluating Provider performance, including advance communication of the specific measures that shall be used to determine quality performance, the methodology for calculating and assessing Provider performance, and any quality gating criteria that may be included in the APM design; and

4.14.10.1.1.4. The frequency at which the MCO shall regularly report cost and quality data related to APM performance to Providers, and the information that shall be included in each report.

4.14.10.1.2 Additional information may be required by DHHS in supplemental guidance. All information provided to DHHS shall be made available to Providers eligible to participate in or already participating in the APM unless the MCO requests and receives DHHS approval for specified information not to be made available.

4.14.10.2 Standardized Assessment of Alternative Payment Model Usage

4.14.10.2.1 The MCO shall complete, attest to the contents of, and submit to DHHS the HCP-LAN APM assessment²⁷ in accordance with Exhibit O.

²⁷ The MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).

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4.14.10.2.2 Thereafter, the MCO shall complete, attest to the contents of, and submit to DHHS the HCP-LAN APM assessment in accordance with Exhibit O and/or the DHHS Medicaid APM Strategy.

4.14.10.2.3 If the MCO reaches an agreement with DHHS that its implementation of the required APM model(s) may be delayed, the MCO shall comply with all terms set forth by DHHS for the additional and/or alternative timing of the MCO's submission of the HCP-LAN APM assessment.

4.14.10.3 Additional Reporting on Alternative Payment Model Outcomes

4.14.10.3.1 The MCO shall provide additional information required by DHHS in Exhibit O or other DHHS guidance on the type, usage, effectiveness and outcomes of its APMs.

4.14.11 Development Period for MCO Implementation

4.14.11.1 Consistent with the requirements for new MCOs, outlined in Section 4.14.8 (Qualifying Alternative Payment Models) above, DHHS acknowledges that MCOs may require time to advance their MCO Implementation Plan. DHHS shall provide additional detail, in its Medicaid APM Strategy, that describes how MCOs should expect to advance use of APMs over time.

4.14.12 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters

4.14.12.1 [Amendment #5:] The MCO's APM Implementation Plan shall indicate the quantitative, measurable clinical outcomes the MCO seeks to improve through its APM and QAPI initiative(s).

4.14.12.2 At a minimum, the MCO shall address the priorities identified in this Section 4.14.12 (Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters) and all additional priorities identified by DHHS in the DHHS Medicaid APM Strategy.

4.14.12.3 State Priorities in RSA 126-AA

4.14.12.3.1 [Amendment #5:] The MCO's APM Implementation Plan and/or QAPI Plan shall address the following priorities:

4.14.12.3.1.1. Opportunities to decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;

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4.14.12.3.1.2. Opportunities to reduce preventable admissions and thirty (30)-day hospital readmission for all causes;

4.14.12.3.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of NAS births;

4.14.12.3.1.4. Opportunities to better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with IDNs to advance the goals of the Building Capacity for Transformation waiver;

4.14.12.3.1.5. Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing generic prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing polypharmacy, as described in Section 4.2.5 (Medication Management);

4.14.12.3.1.6. Opportunities to enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.5 (Payment to Substance Use Disorder Providers) of this Agreement); and

4.14.12.3.1.7. Opportunities to address social determinants of health (further addressed in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address "ED boarding," in which Members that would be best treated in the community remain in the ED.

4.14.12.4 Alternative Payment Models for Substance Use Disorder Treatment

4.14.12.4.1 As is further described in Section 4.11.6.5 (Payment to Substance Use Disorder Providers), the MCO shall include in its APM Implementation Plan:

4.14.12.4.1.1. At least one (1) APM that promotes the coordinated and cost-effective delivery of high-quality care to infants born with NAS; and

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4.14.12.4.1.2. At least one (1) APM that promotes greater use of Medication-Assisted Treatment.

4.14.12.5 Emerging State Medicaid and Public Health Priorities

4.14.12.5.1 The MCO shall address any additional priorities identified by DHHS in the Medicaid APM Plan or related guidance.

4.14.12.5.2 If DHHS adds or modifies priorities after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of its APM Implementation Plan.

4.14.13 Physician Incentive Plans

4.14.13.1 The MCO shall submit all Physician Incentive Plans to DHHS for review as part of its APM Implementation Plan or upon development of Physician Incentive Plans that are separate from the MCO's APM Implementation Plan.

4.14.13.2 The MCO shall not implement Physician Incentive Plans until they have been reviewed and approved by DHHS.

4.14.13.3 Any Physician Incentive Plan, including those detailed within the MCO's APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to "MA organization," "CMS," and "Medicare beneficiaries" should be read as references to "MCO," "DHHS," and "Members," respectively. These include that:

4.14.13.3.1 The MCO may only operate a Physician Incentive Plan if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or Physician Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.14.13.3.2 If the MCO puts a physician or Physician Group at substantial financial risk for services not provided by the physician or Physician Group, the MCO shall ensure that the physician or Physician Group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(2); 42 CFR 438.3(i)]

4.14.13.4 The MCO shall submit to DHHS annually, at the time of its annual HCP-LAN assessment, a detailed written report of any implemented (and previously reviewed) Physician Incentive Plans, as described in Exhibit O.

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4.14.13.5 Annual Physician Incentive Plan reports shall provide assurance satisfactory to DHHS that the requirements of 42 CFR 438.208 are met. The MCO shall, upon request, provide additional detail in response to any DHHS request to understand the terms of Provider payment arrangements.

4.14.13.6 The MCO shall provide to Members upon request the following information:

4.14.13.6.1 Whether the MCO uses a Physician Incentive Plan that affects the use of referral services;

4.14.13.6.2 The type of incentive arrangement; and

4.14.13.6.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)].

4.15 Provider Payments

4.15.1 General Requirements

4.15.1.1 The MCO shall not, directly or indirectly, make payment to a physician or Physician Group or to any other Provider as an inducement to reduce or limit Medically Necessary Services furnished to a Member. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 438.3(i)]

4.15.1.2 The MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) [Section 1903 of the Social Security Act]:

4.15.1.2.1 Furnished under the MCO by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.

4.15.1.2.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act when the person knew or had any reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

4.15.1.2.3 Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the

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individual or entity, unless the State determines there is good cause not to suspend such payments.

4.15.1.2.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

4.15.1.2.5 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(2)(A) - (C) of the Social Security Act; section 1903(i)(16) - (17) of the Social Security Act]

4.15.1.3 No payment shall be made to a Participating Provider other than by the MCO for services covered under the Agreement between DHHS and the MCO, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR, or when DHHS makes direct payments to Participating Providers for graduate medical education costs approved under the Medicaid State Plan, or have been otherwise approved by CMS. [42 CFR 438.60]

4.15.1.4 The MCO shall reimburse Providers based on the Current Procedural Terminology (CPT) code's effective date. To the extent a procedure is required to be reimbursed under the Medicaid State Plan but no CPT code or other billing code has been provided by DHHS, the MCO shall contact DHHS and obtain a CPT code and shall retroactively reimburse claims based on the CPT effective date as a result of the CPT annual updates.

4.15.1.4.1 [Amendment #2:] For MCO provider contracts based on NH Medicaid fee schedules, the MCO shall reimburse providers for annual and periodic fee schedule adjustments in accordance with their effective dates.

4.15.1.5 The MCO shall permit Providers up to one hundred and twenty (120) calendar days to submit a timely claim. The MCO shall establish reasonable policies that allow for good cause exceptions to the one hundred and twenty (120) calendar day timeframe.

4.15.1.6 Good cause exceptions shall accommodate foreseeable and unforeseeable events such as:

4.15.1.6.1 A Member providing the wrong Medicaid identification number,

4.15.1.6.2 Natural disasters; or

4.15.1.6.3 Failed information technology systems.

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4.15.1.7 The Provider should be provided a reasonable opportunity to rectify the error, once identified, and to either file or re-file the claim.

4.15.1.8 Within the first one hundred and eighty (180) calendar days of the Program Start Date, DHHS has discretion to direct MCOs to extend the one hundred and twenty (120) calendar days on case by case basis.

4.15.1.9 The MCO shall pay interest on any Clean Claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

4.15.1.10 The MCO shall collect data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and Care Coordination efforts. [42 CFR 438.242(b)(3)(iii)]

4.15.1.11 The MCO shall implement and maintain arrangements or procedures for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud, to DHHS. [42 CFR 438.608(a)(2)]

4.15.2 Hospital-Acquired Conditions and Provider-Preventable Conditions

4.15.2.1 The MCO shall comply with State and federal laws requiring nonpayment to a Participating Provider for Hospital-Acquired Conditions and for Provider-Preventable Conditions.

4.15.2.2 The MCO shall not make payments to a Provider for a Provider-Preventable Condition that meets the following criteria:

4.15.2.2.1 Is identified in the Medicaid State Plan;

4.15.2.2.2 Has been found by NH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

4.15.2.2.3 Has a negative consequence for the Member;

4.15.2.2.4 Is auditable; and

4.15.2.2.5 Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.3(g); 42 CFR 438.6(a)(12)(i); 42 CFR 447.26(b)]

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4.15.2.3 The MCO shall require all Providers to report Provider-Preventable Conditions associated with claims for payment or Member treatments for which payment would otherwise be made, in accordance with Exhibit O. [42 CFR 438.3(g); 42 CFR 434.6(a)(12)(ii); 42 CFR 447.26(d)]

4.15.3 Federally Qualified Health Centers and Rural Health Clinics

4.15.3.1 FQHCs and RHCs shall be paid at minimum the encounter rate paid by DHHS at the time of service, and shall also be paid for DHHS-specified CPT codes outside of the encounter rates.

4.15.3.2 The MCO shall not provide payment to an FQHC or RHC that is less than the level and amount of payment which the MCO would make for the services if the services were furnished by a Provider which is not an FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Social Security Act]

4.15.3.3 [Amendment #5:] The MCO may ~~shall~~ enter into Alternative Payment Models with FQHCs, RHCs, and/or other health or family planning clinics or their designated contracting organizations as negotiated and agreed upon with DHHS in the MCO's APM Implementation Plan and as described by DHHS in the Medicaid APM Strategy.

4.15.4 Hospice Payment Rates

4.15.4.1 The Medicaid hospice payment rates shall be calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services.

4.15.5 Community Mental Health Programs

4.15.5.1 The MCO shall, as described in Section 4.11.5.2 (Payment to Community Mental Health Programs and Community Mental Health Providers), meet the specific payment arrangement criteria in contracts with CMH Programs and CMH Providers for services provided to Members.

4.15.5.2 [Amendment #3:] Subject to CMH Provider Agreement modification, the MCO shall waive its CMH Program contracted minimum Maintenance of Effort (MOE) requirements for the purpose of providing COVID-19 Public Health Emergency fiscal relief during the SFY 2020 period.

4.15.5.2.1 [Amendment #9:] "Maintenance of effort" (MOE), defined in the payer/provider contract for a specified period of time,

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commonly refers to minimum performance requirements which the provider must achieve to earn or retain all or a portion of the provider's capitated payments either through reimbursement withheld by the payer or adjusted after reconciliation and settlement of the provider's payment(s) for the period.

4.15.5.3 [Amendment #3:] Such MOE waiver described in Section 4.15.5.2 shall not inadvertently cause reductions in the MCO's CMH Program contracted capitation rates in future rating periods.

4.15.5.4 [Amendment #5:] The MCO shall not extend the MOE relief waiver described in Sections 4.15.5.2 and 4.15.5.3 beyond March 31, 2021, unless a Public Health Emergency is extended beyond the 31st in which case the MOE relief shall nonetheless end on June 30, 2021.

4.15.5.4.1 [Amendment #10:] [Amendment #8:] The MCO shall limit any MOE clawback that is determined to fifty percent (50%) for the period July 1, 2023 ~~2022~~ through August 31, 2024 ~~December 31, 2022~~; and limit MOE clawback to seventy percent (70%) for the period January 1, 2023 through June 30, 2023.

4.15.5.4.1.1. [Amendment #8:] The MCO shall include in their contracts with CMHCs, the following:

4.15.5.4.1.1.1 [Amendment #8:] Utilization of MOE thresholds in place for the SFY 2021 fiscal period.

4.15.5.4.1.1.2 [Amendment #8:] CMHC requirements to explicitly reserve for MOE liability for failure to meet the threshold.

4.15.5.4.1.1.3 [Amendment #8:] Agreement the MCO shall clawback no more than fifty percent (50%) of any individual CMHC's MOE liability/reserve after the year end reconciliation is complete following two months of runout for SFY 2022.

4.15.5.4.1.1.4 [Amendment #8:] Requirements the CMHCs shall contractually commit to applying its portion of any "retained reserve account" to workforce and provide a detailed accounting to the Department.

4.15.5.4.1.1.5 [Amendment #8:] The MCO's clawback shall be calculated as a part of the Medical

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Loss Ratio provisions in the MCO's Agreement with DHHS.

4.15.5.4.1.1.6 [Amendment #8:] Should there be materiality of substituted services by non-CMHC Providers determined by the Department's actuary due to MOE adherence, the actuarial value and materiality of partial hospitalization services shall be acknowledged as such with a contractual adjustment.

4.15.5.5 [Amendment #6:] The MCO shall remit directed payment(s) to eligible Community Mental Health Programs (CMHPs) in accordance with separate guidance, as follows:

4.15.5.5.1 [Amendment #6:] For the rating period September 1, 2019 through June 30, 2020 directed payment amounts determined by DHHS shall comprise uniform dollar or percentage increases for Community Mental Health Programs for Assertive Community Treatment, Mobile Crisis Services, Same Day Access upon New Hampshire Hospital Discharge, and Step Down Community Residence Beds, as approved by CMS.

4.15.5.5.2 [Amendment #6:] For the rating period July 1, 2020 through June 30, 2021, directed payment amounts determined by DHHS shall comprise a uniform dollar increase for assertive community treatment services, mobile crisis response services, specialty residential services, same day/next day access upon hospital/designated receiving facility discharges, and step down community residence beds for individuals dually diagnosed with serious mental illness and development disabilities, as approved by CMS.

4.15.5.5.3 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment amounts determined by DHHS shall comprise a fee schedule adjustment or uniform dollar increase for assertive community treatment, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, consistent illness management and recovery services, and step down community residence beds for individuals dually diagnosed with serious mental illness and developmental disabilities, within the Community Mental Health Programs class of network providers as approved by CMS, including any alternate CMS-approved directed payment methodology.

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4.15.5.5.4 [Amendment #10:] [Amendment #8:] For the rating period July 1, 2023 2022 through August 31, 2024June 30, 2023, directed payment amounts determined by DHHS shall comprise a fee schedule adjustment or uniform dollar increase for assertive community treatment, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, consistent illness management and recovery services, and step down community residence beds for individuals dually diagnosed with serious mental illness and developmental disabilities, within the Community Mental Health Programs class of network providers as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.5.6 [Amendment #7:] [Amendment #6:] The MCO shall reimburse remit directed payment(s) to eligible Community Mental Health Programs (CMHPs) for Community Residential Services, as follows:

4.15.5.6.1 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise a minimum fee schedule at least at the FFS rates established by DHHS for Community Residential Services.

4.15.5.6.2 [Amendment #10:] [Amendment #8:] For the rating period July 1, 2023 2022 through August 31, 2024June 30, 2023, directed payment remittance shall comprise a minimum fee schedule at least at the FFS rates established by DHHS for Community Residential Services.

4.15.6 Payment Standards for Substance Use Disorder Providers

4.15.6.1 The MCO shall, as described in Section 4.11.6 (Substance Use Disorder), reimburse Substance Use Providers as directed by DHHS.

4.15.7 Payment Standards for Private Duty Nursing Services

4.15.7.1 The MCO shall reimburse private duty nursing agencies for private duty nursing services at least at the FFS rates established by DHHS.

4.15.8 Payment Standards for Indian Health Care Providers

4.15.8.1 The MCO shall pay IHCPs, whether Participating Providers or not, for Covered Services provided to American Indian Members who are eligible to receive services at a negotiated rate between the MCO and the IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the MCO

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would make for the services to a Participating Provider that is not an IHCP. [42 CFR 438.14(b)(2)(i) - (ii)]

4.15.8.2 For contracts involving IHCPs, the MCO shall meet the requirements of FFS timely payment for all I/T/U Providers in its network, including the paying of ninety-five percent (95%) of all Clean Claims within thirty (30) calendar days of the date of receipt; and paying ninety-nine percent (99%) of all Clean Claims within ninety (90) calendar days of the date of receipt. [42 CFR 438.14(b)(2)(iii); ARRA 5006(d); 42 CFR 447.45; 42 CFR 447.46; SMDL 10-001)]

4.15.8.3 IHCPs enrolled in Medicaid as FQHCs but not Participating Providers of the MCO shall be paid an amount equal to the amount the MCO would pay an FQHC that is a Participating Provider but is not an IHCP, including any supplemental payment from DHHS to make up the difference between the amount the MCO pays and what the IHCPs FQHC would have received under FFS. [42 CFR 438.14(c)(1)]

4.15.8.4 When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medicaid State Plan's FFS payment methodology. [42 CFR 438.14(c)(2)]

4.15.8.5 When the amount the IHCP receives from the MCO is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, DHHS shall make a supplemental payment to the IHCP to make up the difference between the amount the MCO pays and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 CFR 438.14(c)(3)]

4.15.9 Transition Housing Program

The MCO shall reimburse Transition Housing Program services at least at the FFS rates established by DHHS.

4.15.10 Payment Standards for DME Providers

4.15.10.1 [Amendment #6:] Beginning January 1, 2020, the MCO shall reimburse DME Providers for DME and DME related services, as _____ follows:
~~[Base Contract:] No earlier than January 1, 2020, the MCO shall reimburse DME Providers for DME and DME related services at 80% of the FFS rates established by DHHS.~~

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4.15.10.1.1 [Amendment #6:] For the rating period September 1, 2019 through June 30, 2020, directed payment remittance shall comprise a minimum fee schedule at 80% of the DHHS FFS fee schedule, as approved by CMS.

4.15.10.1.2 [Amendment #6:] For the rating period July 1, 2020 through June 30, 2021, directed payment remittance shall comprise a minimum fee schedule at 80% of the DHHS FFS fee schedule, as approved by CMS.

4.15.10.1.3 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise a minimum fee schedule at 80% of the DHHS FFS fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.10.1.4 [Amendment #8:] For the rating period July 1, 2022 through June 30, 2023, MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.10.1.5 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.11 [Amendment #3:] Payment Standards for Certain Providers Affected by the COVID-19 Public Health Emergency

4.15.11.1 [Amendment #6:] The MCO shall remit directed payments related to the COVID 19 Public Health Emergency in accordance with separate guidance, as follows: [Amendment #3:] The MCO shall cooperate in implementing CMS-approved COVID-19 Public Health Emergency-related directed payments in accordance with prescribed DHHS guidance.

4.15.11.1.1 [Amendment #6:] For the rating period September 1, 2019 through June 30, 2020, directed payment amounts determined by DHHS shall comprise a uniform percent increase to defined safety net provider classes as approved by CMS.

4.15.11.2 [Amendment #7:] The MCO shall remit directed payments related to funding available through the American Rescue Plan Act of 2021 (ARPA) Section 9817, as follows:

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4.15.11.2.1 [Amendment #7:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise an additional payment calculated by DHHS at a percentage payment increase to defined Home and Community Based Service (HCBS) provider classes (e.g., private duty nursing, home care, personal care, durable medical equipment, substance use disorder residential providers, Community Mental Health Centers) for specified codes in accordance with separate guidance and as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.12 [Amendment #4:] Payment Standards for Directed Payments

4.15.12.1 [Amendment #4:] Any directed payments proposed to CMS shall be described in the program's actuarial certification for the rating period.

4.15.12.2 [Amendment #7:] The term "minimum fee schedule" in this Section 4.15, shall infer the minimum provider reimbursement amount(s) permissible under the terms of this Agreement.

4.15.13 [Amendment #6:] Critical Access Hospitals (CAHs)

4.15.13.1 [Amendment #6:] The MCO shall remit directed payment(s) to CAHs in accordance with separate guidance, as follows:

4.15.13.1.1 [Amendment #6:] For the rating period July 1, 2020 through June 30, 2021, directed payment amounts determined by DHHS shall comprise a uniform rate increase for inpatient discharges and outpatient visits to qualifying CAHs as approved by CMS.

4.15.13.1.2 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.13.1.3 [Amendment #8:] For the rating period July 1, 2022 through June 30, 2023, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology.

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4.15.13.1.4 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology. Qualified directed payments are tied to actual hospital services, including the number of inpatient discharges and outpatient visits reported by qualifying Providers.

4.15.14 [Amendment #6:] Designated Receiving Facilities (DRFs)

4.15.14.1 [Amendment #7] [Amendment #6:] The MCO shall remit minimum directed payments to ~~DHHS approved NH Medicaid enrolled DRFs as designated by the Commissioner, in accordance with separate guidance, as follows:~~

4.15.14.1.1 [Amendment #7] [Amendment #6:] For the July 1, 2021 through June 30, 2022 rating period, the MCO directed payment remittance to the Peer Group 06 provider shall comprise the minimum ~~Peer Group 01 and 07, Peer Group 02, Peer Group 06, and Peer Group 09 State Plan~~ DRG fee schedule payment amounts described in Section 6.2.41.1, and the State Plan rate for Hampstead Hospital.

4.15.14.1.2 [Amendment #8:] For the July 1, 2022 through June 30, 2023 rating period, the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 State Plan DRG fee schedule payment amounts described in Section 6.2.41.1.

4.15.14.1.3 [Amendment #10:] For the July 1, 2023 through August 31, 2024 rating period, the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 State Plan DRG fee schedule payment amounts described in Section 6.2.41.1.

4.15.15 [Amendment #7:] Neuropsychological Testing Services

4.15.15.1 [Amendment #7:] Beginning July 1, 2021, the MCO shall reimburse eligible providers for covered neuropsychological testing services, as follows:

4.15.15.1.1 [Amendment #7:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

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4.15.15.1.2 [Amendment #8] For the rating period July 1, 2022 through June 30, 2023, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.15.1.3 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.16 [Amendment #8:] New Hampshire Hospital and Hampstead Hospital

4.15.16.1 [Amendment #10] [Amendment #8:] Beginning July 1, 2022, the MCO shall reimburse inpatient psychiatric services delivered in state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

4.15.16.1.1 [Amendment #8:] For the rating period July 1, 2022 through June 30, 2023, the facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

4.15.16.1.2 [Amendment #10:] [Amendment #8:] For the rating period July 1, 2023 through August 31, 2024, the facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

4.15.16.2 [Amendment #10:] The MCO shall reimburse inpatient psychiatric professional services delivered in the state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

4.15.16.2.1 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, directed payment amounts shall comprise minimum fee schedule payments at no less than the Medicare rates for inpatient psychiatric professional services delivered in the state-owned facilities.

4.15.17 [Amendment #10:] Payment Standard for Birthing Centers

4.15.17.1 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services at no less than NH Medicaid fee schedule rates.

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4.15.18 [Amendment #10:] Qualifying Children's Hospitals

4.15.18.1 [Amendment #10:] The MCO shall remit directed payments to qualifying Children's Hospitals substantively serving NH Medicaid Members, in accordance with separate guidance, as follows:

4.15.18.2 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, a directed payment add-on amount in addition to the MCO's negotiated rate shall be awarded to qualifying Children's Hospitals for each eligible inpatient and outpatient hospital service encounter as approved by CMS.

4.15.19 [Amendment #10:] Payment Standard for Ambulance Services

4.15.19.1 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Providers for all ambulance and chair car Covered Services at no less than NH Medicaid fee schedule rates.

4.16 Readiness Requirements Prior to Operations

4.16.1 General Requirements

4.16.1.1 Prior to the Program Start Date, the MCO shall demonstrate to DHHS's satisfaction its operational readiness and its ability to provide Covered Services to Members at the start of this Agreement in accordance with 42 CFR 438.66(d)(2), (d)(3), and (d)(4). [42 CFR 437.66(d)(1)(i).

4.16.1.2 The readiness review requirements shall apply to all MCOs regardless of whether they have previously contracted with DHHS. [42 CFR 438.66((D(1)(II))]

4.16.1.3 The MCO shall accommodate Readiness desk and site Reviews, including documentation review and system demonstrations as defined by DHHS.

4.16.1.4 The readiness review requirements shall apply to all MCOs, including those who have previously covered benefits to all eligibility groups covered under this Agreement. [42 CFR 438.66(d)(2), (d)(3) and (d)(4)]

4.16.1.5 In order to demonstrate its readiness, the MCO shall cooperate in the Readiness Review conducted by DHHS.

4.16.1.6 If the MCO is unable to demonstrate its ability to meet the requirements of this Agreement, as determined solely by DHHS, within the timeframes determined solely by DHHS, then DHHS shall

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have the right to terminate this Agreement in accordance with Section 7.1 (Termination for Cause).

4.16.1.7 The MCO shall participate in all DHHS trainings in preparation for implementation of the Agreement.

4.16.2 Emergency Response Plan

4.16.2.1 The MCO shall submit an Emergency Response Plan to DHHS for review prior to the Program Start Date.

4.16.2.2 The Emergency Response Plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

4.16.2.2.1 Staff and Provider training;

4.16.2.2.2 Essential business functions and key employees within the organization necessary to carry them out;

4.16.2.2.3 Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

4.16.2.2.4 Communication with staff, Members, Providers, Subcontractors and suppliers when normal systems are unavailable;

4.16.2.2.5 Plans to ensure continuity of services to Providers and Members;

4.16.2.2.6 How the MCO shall coordinate with and support DHHS and the other MCOs; and

4.16.2.2.7 How the plan shall be tested, updated and maintained.

4.16.2.3 On an annual basis, or as otherwise specified in Exhibit O, the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.

4.17 Managed Care Information System

4.17.1 System Functionality

4.17.1.1 The MCO shall have a comprehensive, automated, and integrated MCIS that:

4.17.1.1.1 Collects, analyzes, integrates, and reports data [42 CFR 438.242(a)];

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4.17.1.1.2 Provides information on areas, including but not limited to utilization, claims, grievances and appeals [42 CFR 438.242(a)];

4.17.1.1.3 Collects and maintains data on Members and Providers, as specified in this Agreement and on all services furnished to Members, through an Encounter Data system [42 CFR 438.242(b)(2)];

4.17.1.1.4 Is capable of meeting the requirements listed throughout this Agreement; and

4.17.1.1.5 Is capable of providing all of the data and information necessary for DHHS to meet State and federal Medicaid reporting and information regulations.

4.17.1.2 The MCO's MCIS shall be capable of submitting Encounter Data, as detailed in Section 5.1.3 (Encounter Data) of this Agreement. The MCO shall provide for:

4.17.1.2.1 Collection and maintenance of sufficient Member Encounter Data to identify the Provider who delivers any item(s) or service(s) to Members;

4.17.1.2.2 Submission of Member Encounter Data to DHHS at the frequency and level of detail specified by CMS and by DHHS;

4.17.1.2.3 Submission of all Member Encounter Data that NH is required to report to CMS; and

4.17.1.2.4 Submission of Member Encounter Data to DHHS in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as specified in this Agreement. [42 CFR 438.242(c)(1) - (4); 42 CFR 438.818]

4.17.1.3 All Subcontractors shall meet the same standards, as described in this Section 4.17 (Managed Care Information System) of the Agreement, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a Subcontractor with respect to its provided functions.

4.17.1.4 The MCO MCIS shall include, but not be limited to:

4.17.1.4.1 Management of Recipient Demographic Eligibility and Enrollment and History;

4.17.1.4.2 Management of Provider Enrollment and Credentialing;

4.17.1.4.3 Benefit Plan Coverage Management, History, and Reporting;

4.17.1.4.4 Eligibility Verification;

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- 4.17.1.4.5 Encounter Data;
 - 4.17.1.4.6 Reference File Updates;
 - 4.17.1.4.7 Service Authorization Tracking, Support and Management;
 - 4.17.1.4.8 Third Party Coverage and Cost Avoidance Management;
 - 4.17.1.4.9 Financial Transactions Management and Reporting;
 - 4.17.1.4.10 Payment Management (Checks, electronic funds transfer (EFT), Remittance Advices, Banking);
 - 4.17.1.4.11 Reporting (Ah hoc and Pre-Defined/Scheduled and On-Demand);
 - 4.17.1.4.12 Call Center Management;
 - 4.17.1.4.13 Claims Adjudication;
 - 4.17.1.4.14 Claims Payments; and
 - 4.17.1.4.15 QOS metrics.
- 4.17.1.5 Specific functionality related to the above shall include, but is not limited to, the following:
- 4.17.1.5.1 The MCIS Membership management system shall have the capability to receive, update, and maintain NH's Membership files consistent with information provided by DHHS;
 - 4.17.1.5.2 The MCIS shall have the capability to provide daily updates of Membership information to subcontractors or Providers with responsibility for processing claims or authorizing services based on Membership information;
 - 4.17.1.5.3 The MCIS's Provider file shall be maintained with detailed information on each Provider sufficient to support Provider enrollment and payment and also meet DHHS's reporting and Encounter Data requirements;
 - 4.17.1.5.4 The MCIS's claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system;
 - 4.17.1.5.5 The MCIS's Services Authorization system shall be integrated with the claims processing system;

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4.17.1.5.6 The MCIS shall be able to maintain its claims history with sufficient detail to meet all DHHS reporting and encounter requirements;

4.17.1.5.7 The MCIS's credentialing system shall have the capability to store and report on Provider specific data sufficient to meet the Provider credentialing requirements, Quality Management, and Utilization Management Program Requirements;

4.17.1.5.8 [Amendment #5:] The MCIS shall be bi-directionally linked to the other operational systems maintained by DHHS; in order to ensure that data captured in encounter records accurately matches data in Member, Provider, claims and authorization files, and in order to enable Encounter Data to be utilized for Member profiling, Provider profiling, claims validation, fraud, waste and abuse monitoring activities, quality improvement, and any other research and reporting purposes defined by DHHS; and

4.17.1.5.9 The Encounter Data system shall have a mechanism in place to receive, process, and store the required data.

4.17.1.6 The MCO system shall be compliant with the requirements of HIPAA and 42 CFR Part 2, including privacy, security, NPI, and transaction processing, including being able to process electronic data interchange (EDI) transactions in the ASC 5010 format. This also includes IRS Pub 1075 where applicable.

4.17.1.7 The MCO system shall be compliant with Section 6504(a) of the Affordable Care Act, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act. [42 CFR 438.242(b)(1)]

4.17.1.8 MCIS capability shall include, but not be limited to the following:

4.17.1.8.1 Provider network connectivity to EDI and Provider portal systems;

4.17.1.8.2 Documented scheduled down time and maintenance windows, as agreed upon by DHHS, for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

4.17.1.8.3 DHHS on-line web access to applications and data required by the State to utilize agreed upon workflows, processes,

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and procedures (reviewed by DHHS) to access, analyze, or utilize data captured in the MCO system(s) and to perform appropriate reporting and operational activities;

4.17.1.8.4 DHHS access to user acceptance testing (UAT) environment for externally accessible systems including websites and secure portals;

4.17.1.8.5 Documented instructions and user manuals for each component; and

4.17.1.8.6 Secure access.

4.17.1.9 Managed Care Information System Up-Time

4.17.1.9.1 Externally accessible systems, including telephone, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year, except for scheduled maintenance upon notification of and pre-approval by DHHS. The maintenance period shall not exceed four (4) consecutive hours without prior DHHS approval.

4.17.1.9.2 MCO shall provide redundant telecommunication backups and ensure that interrupted transmissions shall result in immediate failover to redundant communications path as well as guarantee data transmission is complete, accurate and fully synchronized with operational systems.

4.17.2 Information System Data Transfer

4.17.2.1 Effective communication between the MCO and DHHS requires secure, accurate, complete, and auditable transfer of data to/from the MCO and DHHS data management information systems. Elements of data transfer requirements between the MCO and DHHS management information systems shall include, but not be limited to:

4.17.2.1.1 DHHS read access to all MCM data in reporting databases where data is stored, which includes all tools required to access the data at no additional cost to DHHS;

4.17.2.1.2 Exchanges of data between the MCO and DHHS in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target;

4.17.2.1.3. Secure (encrypted) communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to

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identify and resolve issues according to the timelines set forth by the State;

4.17.2.1.4 Collaborative relationships with DHHS, its MMIS fiscal agent, and other interfacing entities to effectively implement the requisite exchanges of data necessary to support the requirements of this Agreement;

4.17.2.1.5 MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

4.17.2.1.6 Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling that, to the maximum extent possible, automate the ETL processes, and provide for source to target or source to specification mappings;

4.17.2.1.7 Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts; and

4.17.2.1.8 A given day's data transmissions, as specified in this Section 4.17.2 (Information System Data Transfer) of the Agreement, are to be downloaded to DHHS according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions shall be included in the next batch transmission.

4.17.2.2 The MCO shall designate a single point of contact to coordinate data transfer issues with DHHS.

4.17.2.3 DHHS shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and DHHS staff for project plans documentation, issues tracking, deliverables, and other project-related artifacts.

4.17.2.4 Data transmissions from DHHS to the MCO shall include, but not be limited to the following:

4.17.2.4.1 Provider Extract (Daily);

4.17.2.4.2 Recipient Eligibility Extract (Daily);

4.17.2.4.3 Recipient Eligibility Audit/Roster (Monthly);

4.17.2.4.4 Medical and Pharmacy Service Authorizations (Daily);

4.17.2.4.5 Medicare and Commercial Third Party Coverage (Daily);

4.17.2.4.6 Claims History (Bi-Weekly); and

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4.17.2.4.7 Capitation Payment data (Monthly).

4.17.2.5 Data transmissions from the MCO to DHHS shall include, but not be limited to the following:

4.17.2.5.1 Member Demographic changes (Daily);

4.17.2.5.2 Member Primary Care Physician Selection (Daily);

4.17.2.5.3 MCO Provider Network Data (Daily);

4.17.2.5.4 Medical and Pharmacy Service Authorizations (Daily);

4.17.2.5.5 Member Encounter Data including paid, denied, adjustment transactions by pay period (Weekly);

4.17.2.5.6 Financial Transaction Data (Weekly);

4.17.2.5.7 Updates to Third Party Coverage Data (Weekly); and

4.17.2.5.8 Behavioral Health Certification Data (Monthly).

4.17.2.6 The MCO shall provide DHHS staff with access to timely and complete data and shall meet the following requirements:

4.17.2.6.1 All exchanges of data between the MCO and DHHS shall be in a format, file record layout, and scheduled as prescribed by DHHS;

4.17.2.6.2 The MCO shall work collaboratively with DHHS, DHHS's MMIS fiscal agent, the NH Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

4.17.2.6.3 The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide DHHS with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between DHHS and the MCO, including any MCO/Subcontractor locations supporting the NH program;

4.17.2.6.4 The MCO shall provide support to DHHS and its fiscal agent to prove the validity, integrity and reconciliation of its data, including Encounter Data;

4.17.2.6.5 The MCO shall be responsible for correcting data extract errors in a timeline set forth by DHHS as outlined within this Agreement;

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4.17.2.6.6 Access shall be secure and data shall be encrypted in accordance with HIPAA regulations and any other applicable State and federal law; and

4.17.2.6.7 Secure access shall be managed via passwords/pins/and any operational methods used to gain access as well as maintain audit logs of all users access to the system.

4.17.3 Systems Operation and Support

4.17.3.1 Systems operations and support shall include, but not be limited to:

4.17.3.1.1 On-call procedures and contacts;

4.17.3.1.2 Job scheduling and failure notification documentation;

4.17.3.1.3 Secure (encrypted) data transmission and storage methodology;

4.17.3.1.4 Interface acknowledgements and error reporting;

4.17.3.1.5 Technical issue escalation procedures;

4.17.3.1.6 Business and Member notification;

4.17.3.1.7 Change control management;

4.17.3.1.8 Assistance with UAT and implementation coordination;

4.17.3.1.9 Documented data interface specifications – data imported and extracts exported including database mapping specifications;

4.17.3.1.10 Disaster Recovery and Business Continuity Plan;

4.17.3.1.11 Journaling and internal backup procedures, for which facility for storage shall be class 3 compliant; and

4.17.3.1.12 Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

4.17.3.2 The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and shall provide:

4.17.3.2.1 Network diagram that fully defines the topology of the MCO's network;

4.17.3.2.2 DHHS/MCO connectivity;

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4.17.3.2.3 Any MCO/Subcontractor locations requiring MCIS access/support; and

4.17.3.2.4 Web access for DHHS staff, Providers and recipients.

4.17.3.3 [Amendment #9:] The MCO shall utilize either its own or the State's open model Electronic Visit Verification (EVV) system as prescribed by the Department in separate guidance for all Medicaid personal care services and home health Covered Services that require an in-home visit by a Provider in accordance with Section 12006(a) of the 21st Century Cures Act. This applies to personal care services provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver, as applicable.

4.17.4 Ownership and Access to Systems and Data

4.17.4.1 The MCO shall make available to DHHS and, upon request, to CMS all collected data. [42 CFR 438.242(b)(4)]

4.17.4.2 All data accumulated as part of the MCM program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in the media format and schedule prescribed by DHHS, and affirmatively and securely destroyed if required by DHHS.

4.17.4.3 Systems enhancements developed specifically, and data accumulated, as part of the MCM program shall remain the property of the State. Source code developed for the MCM program shall remain the property of the MCO but shall be held in escrow.

4.17.4.4 The MCO shall not destroy or purge DHHS's data unless directed to or agreed to in writing by DHHS. The MCO shall archive data only on a schedule agreed upon by DHHS and the data archive process shall not modify the data composition of the source records. All DHHS archived data shall be retrievable for DHHS in the timeframe set forth by DHHS.

4.17.4.5 The MCO shall provide DHHS with system reporting capabilities that shall include access to pre-designed and agreed-upon scheduled reports, as well as the ability to respond promptly to ad-hoc requests to support DHHS data and information needs.

4.17.4.6 DHHS acknowledges the MCO's obligations to appropriately protect data and system performance, and the parties agree to work together to ensure DHHS information needs can be met while minimizing risk and impact to the MCO's systems.

4.17.4.7 Records Retention

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4.17.4.7.1 The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than ten (10) years from the date of termination of this Agreement.

4.17.4.7.2 Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation.

4.17.4.7.3 Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHHS, if DHHS approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

4.17.4.7.4 Upon expiration of the ten (10) year retention period and upon request, the subject records shall be transferred to DHHS's possession.

4.17.4.7.5 No records shall be destroyed or otherwise disposed of without the prior written consent of DHHS.

4.17.5 Web Access and Use by Providers and Members

4.17.5.1 The MCIS shall include web access for use by and support to Participating Providers and Members.

4.17.5.2 The services shall be provided at no cost to the Participating Provider or Members.

4.17.5.3 All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

4.17.5.4 The MCO shall create secure web access for Medicaid Providers and Members and authorized DHHS staff to access case-specific information; this web access shall fulfill the following requirements, and shall be available no later than the Program Start Date:

4.17.5.4.1 Providers shall have the ability to electronically submit service authorization requests and access and utilize other Utilization Management tools;

4.17.5.4.2 Providers and Members shall have the ability to download and print any needed Medicaid MCO program forms and other information;

4.17.5.4.3 Providers shall have an option to e-prescribe without electronic medical records or hand held devices;

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4.17.5.4.4 The MCO shall support Provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es);

4.17.5.4.5 Providers shall have access to drug information;

4.17.5.4.6 The website shall provide an e-mail link to the MCO to permit Providers and Members or other interested parties to e-mail inquiries or comments.

4.17.5.4.7 The website shall provide a link to the State's Medicaid website;

4.17.5.4.8 The website shall be secure and HIPAA compliant in order to ensure the protection of PHI and Medicaid recipient confidentiality.

4.17.5.4.9 Access shall be limited to verified users via passwords and any other available industry standards.

4.17.5.4.10 Audit logs shall be maintained reflecting access to the system and random audits shall be conducted; and

4.17.5.4.11 The MCO shall ensure that any PHI, PI or other Confidential Information solicited on the website, shall not be stored or captured on the website and shall not be further disclosed except as provided by this Agreement.

4.17.5.5 The MCO shall manage Provider and Member access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist Providers and Members with gaining access and utilizing the web portal.

4.17.5.6 System Support Performance Standards shall include:

4.17.5.6.1 Email inquiries – one (1) business day response;

4.17.5.6.2 New information posted within one (1) business day of receipt, and up to two (2) business days of receipt for materials that shall be made ADA compliant with Section 508 of the Rehabilitation Act;

4.17.5.6.3 Routine maintenance;

4.17.5.6.4 Standard reports regarding portal usage such as hits per month by Providers/Members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports; and

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4.17.5.6.5 Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, Internet Explorer, Firefox, Safari, etc.). If user does not have compliant browser, MCO shall redirect user to site to install appropriate browser.

4.17.6 Contingency Plans and Quality Assurance

4.17.6.1 Critical systems within the MCIS support the delivery of critical medical services to Members and reimbursement to Providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

4.17.6.2 The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to NH within twenty-four (24) hours of incident onset.

4.17.6.3 The MCO shall ensure that the NH PHI data, data processing, and data repositories are securely segregated from any other account or project, and that MCIS is under appropriate configuration management and change management processes and subject to DHHS notification requirements.

4.17.6.4 The MCO shall manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files that reflect the source, type and user associated with a transaction.

4.17.6.5 Archiving processes shall not modify the data composition of DHHS's records, and archived data shall be retrievable at the request of DHHS. Archiving shall be conducted at intervals agreed upon between the MCO and DHHS.

4.17.6.6 The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between Providers, Provider billing agents/clearing houses, or DHHS and the MCO.

4.17.6.7 Audit logs of activities shall be maintained and periodically reviewed to ensure compliance with security and access rights granted to users.

4.17.6.8 In accordance with Exhibit O, the MCO shall submit the following documents and corresponding checklists for DHHSs review:

4.17.6.8.1 Disaster Recovery Plan;

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4.17.6.8.2 Business Continuity Plan;

4.17.6.8.3 Security Plan;

4.17.6.8.4 The following documents which, if after the original documents are submitted the MCO makes modifications to them, the revised redlined documents and any corresponding checklists shall be submitted for DHHS review:

4.17.6.8.4.1. Risk Management Plan,

4.17.6.8.4.2. Systems Quality Assurance Plan,

4.17.6.8.4.3. Confirmation of 5010 compliance and Companion Guides, and

4.17.6.8.4.4. Confirmation of compliance with IRS Publication 1075.

4.17.6.9 Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements, at a minimum, shall be part of the MCO's change management process:

4.17.6.9.1 The complete system shall have proper configuration management/change management in place (to be reviewed by DHHS).

4.17.6.9.2 The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

4.17.6.9.3 The MCO shall provide DHHS with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to Subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and DHHS and/or the fiscal agent.

4.17.6.9.4 DHHS retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

4.17.6.9.5 The MCO shall provide DHHS with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day.

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4.17.6.9.6 The MCO shall provide DHHS with official points of contact for MCIS issues on an ongoing basis.

4.17.6.9.7 A NH program centralized electronic repository shall be provided that shall permit full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and any project artifacts. All items shall be turned over to DHHS upon request.

4.17.6.9.8 The MCO shall ensure appropriate testing is done for all system changes. MCO shall also provide a test system for DHHS to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI data of any Member.

4.17.6.9.9 The MCO shall make timely changes or defect fixes to data interfaces and execute testing with DHHS and other applicable entities to validate the integrity of the interface changes.

4.17.6.10 DHHS, or its agent, may conduct a Systems readiness review to validate the MCO's ability to meet the MCIS requirements.

4.17.6.11 The System readiness review may include a desk review and/or an onsite review. If DHHS determines that it is necessary to conduct an onsite review, the MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from DHHS.

4.17.6.12 For purposes of this Section of the Agreement, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by DHHS or its authorized agent in connection with the onsite reviews.

4.17.6.13 If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by DHHS, either correct such deficiency or submit to DHHS a CAP and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, DHHS may impose contractual remedies according to the severity of the deficiency as described in Section 5.5 (Remedies) of this Agreement.

4.17.6.14 QOS metrics shall include:

4.17.6.14.1 System Integrity: The MCO system shall ensure that both user and Provider portal design, and implementation is in accordance with federal standards, regulations and guidelines related to security, confidentiality and auditing (e.g. HIPAA Privacy and Security Rules, National Institute of Security and Technology).

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4.17.6.14.2 The security of the Care Management processing system shall minimally provide the following three types of controls to maintain data integrity that directly impacts QOS. These controls shall be in place at all appropriate points of processing:

4.17.6.14.2.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.

4.17.6.14.2.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.

4.17.6.14.2.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

4.17.6.14.3 System Administration: Ability to comply with HIPAA, ADA, and other State and federal regulations, and perform in accordance with Agreement terms and conditions, ability to provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development.

4.17.6.14.4 The system shall accommodate changes with global impacts (e.g., implementation of electronic health record, e-Prescribe) as well as new transactions at no additional cost.

4.17.7 **[Amendment #5:] Interoperability and Patient Access**

4.17.7.1 [Amendment #5:] The MCO shall comply with the Centers for Medicare & Medicaid Services published final rule, "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers," (referred to as the "CMS Interoperability and Patient Access final rule") to further advance interoperability for Medicaid and Children's Health Insurance Program (CHIP) providers and improve beneficiaries' access to their data.

4.17.7.2 [Amendment #5:] The MCO shall implement this final rule in a manner consistent with existing guidance and the published "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" final rule (referred to as the ONC 21st Century Cures Act final rule), including:

4.17.7.2.1 [Amendment #5:] Patient Access Application Program Interfaces (API). [42 CFR 438.242(b)(5); 42 CFR 457.1233(d); 85

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Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)];

4.17.7.2.2 [Amendment #5:] Provider Directory Application Program Interfaces (API). [42 CFR 438.242(b)(6); 85 Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)]; and

4.17.7.2.3 [Amendment #5:] Implement and maintain a Payer-to-Payer Data Exchange. [42 CFR 438.62(b)(1)(vi)-(vii); 85 Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)].

4.17.7.3 [Amendment #8:] The MCO shall implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60 no later than July 1, 2021, and include(s):

4.17.7.3.1 [Amendment #8:] Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

4.17.7.3.2 [Amendment #8:] Encounter data, including encounter data from any network providers the MCO is compensating on the basis of capitation payments and adjudicated claims and encounter data from any Subcontractors no later than one (1) business day after receiving the data from providers;

4.17.7.3.3 [Amendment #8:] Clinical data, including laboratory results, if the MCO maintains any such data, no later than one (1) business day after the data is received by the state; and

4.17.7.3.4 [Amendment #8:] Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. [42 CFR 438.242(b)(5); 42 CFR 457.1233(d)(2)]

4.17.7.4 [Amendment #8:] The MCO shall implement and maintain a publicly accessible standards-based API no later than July 1, 2021 as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2). [42 CFR 438.242(b)(6); 42 CFR 457.1233(d)(3)]

4.18 Claims Quality Assurance Standards

4.18.1 Claims Payment Standards

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4.18.1.1 [Amendment #7] For purposes of this Section 4.18 (Claims Quality Assurance Standards), DHHS has adopted the claims definitions established by CMS and defined in Section 2.1.25 of this Agreement. [42 CFR 447.45(b)] under the Medicare program, which are as follows:

4.18.1.1.1 ~~"Clean Claim" means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and~~

4.18.1.1.2 ~~"Incomplete Claim" means a claim that is denied for the purpose of obtaining additional information from the Provider.~~

4.18.1.2 Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom by its date stamp or the date an electronic claim is submitted.

4.18.1.3 The paid date is the date a payment check or EFT is issued to the service Provider [42 CFR 447.45(d)(5) - (6); 42 CFR 447.46; sections 1932(f) and 1902(a)(37)(A) of the Act]

4.18.1.4 The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

4.18.1.5 The MCO shall pay or deny ninety-five percent (95%) of Clean Claims within thirty (30) calendar days of receipt; or receipt of additional information.

4.18.1.6 The MCO shall pay ninety-nine percent (99%) of Clean Claims within ninety (90) calendar days of receipt. [42 CFR 447.46; 42 CFR 447.45(d)(2)-(3) and (d)(5)-(6); Sections 1902(a)(37)(A) and 1932(f) of the Social Security Act].

4.18.1.7 The MCO shall request all additional information necessary to process Incomplete Claims from the Provider within thirty (30) calendar days from the date of original claim receipt.

4.18.2 Claims Quality Assurance Program

4.18.2.1 The MCO shall verify the accuracy and timeliness of data reported by Providers, including data from Participating Providers the MCO is compensating through a capitated payment arrangement.

4.18.2.2 The MCO shall screen the data received from Providers for completeness, logic, and consistency [42 CFR 438.242(b)(3)(i)-(ii)].

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4.18.2.3 The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to DHHS, in accordance with Exhibit O.

4.18.2.4 As indicated in Exhibit O, reporting to DHHS shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

The MCO shall implement CAPs to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

4.18.3 Claims Financial Accuracy

4.18.3.1 Claims financial accuracy measures the accuracy of dollars paid to Providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.

4.18.3.2 The MCO shall pay ninety-nine percent (99%) of dollars accurately.

4.18.4 Claims Payment Accuracy

4.18.4.1 Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed.

4.18.4.2 The MCO shall pay ninety-seven percent (97%) of claims accurately.

4.18.5 Claims Processing Accuracy

4.18.5.1 Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed.

4.18.5.2 The MCO shall process ninety-five percent (95%) of all claims correctly.

5 OVERSIGHT AND ACCOUNTABILITY

5.1 Reporting

5.1.1 General Provisions

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5.1.1.1 As indicated throughout this Agreement, DHHS shall document ongoing MCO reporting requirements through Exhibit O and additional specifications provided by DHHS.

5.1.1.2 The MCO shall provide data, reports, and plans in accordance with Exhibit O, this Agreement, and any additional specifications provided by DHHS.

5.1.1.3 The MCO shall comply with all NHID rules for data reporting, including those related to the NH CHIS.

5.1.1.4 The MCO shall make all collected data available to DHHS upon request and upon the request of CMS. [42 CFR 438.242(b)(4)]

5.1.1.5 The MCO shall collect data on Member and Provider characteristics as specified by DHHS and on services furnished to Members through a MCIS system or other methods as may be specified by DHHS. [42 CFR 438.242(b)(2)]

5.1.1.6 The MCO shall ensure that data received from Providers are accurate and complete by:

5.1.1.6.1 Verifying the accuracy and timeliness of reported data;

5.1.1.6.2 Screening the data for completeness, logic, and consistency; and

5.1.1.6.3 Collecting service information in standardized formats to the extent feasible and appropriate. [42 CFR 438.242(b)(3)]

5.1.1.7 DHHS shall at a minimum collect, and the MCO shall provide, the following information, and the information specified throughout the Agreement and within Exhibit O, in order to improve the performance of the MCM program [42 CFR 438.66(c)(1)-(2) and (6)-(11)]:

5.1.1.7.1 Enrollment and disenrollment data;

5.1.1.7.2 Member grievance and appeal logs;

5.1.1.7.3 Medical management committee reports and minutes;

5.1.1.7.4 Audited financial and encounter data;

5.1.1.7.5 The MLR summary reports;

5.1.1.7.6 Customer service performance data;

5.1.1.7.7 Performance on required quality measures; and

5.1.1.7.8 The MCO's QAPI Plan.

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5.1.1.8 The MCO shall be responsible for preparing, submitting, and presenting to the Governor, Legislature, and DHHS a report that includes the following information, or information otherwise indicated by the State:

5.1.1.8.1 A description of how the MCO has addressed State priorities for the MCM Program, including those specified in RSA 126-AA, throughout this Agreement, and in other State statute, policies, and guidelines;

5.1.1.8.2 A description of the innovative programs the MCO has developed and the outcomes associated with those programs;

5.1.1.8.3 A description of how the MCO is addressing social determinants of health and the outcomes associated with MCO-implemented interventions;

5.1.1.8.4 A description of how the MCO is improving health outcomes in the state; and

5.1.1.8.5 Any other information indicated by the State for inclusion in the annual report.

5.1.1.9 Prior to Program Start Date and at any other time upon DHHS request or as indicated in this Agreement, DHHS shall conduct a review of MCO policies and procedures and/or other administrative documentation.

5.1.1.9.1 DHHS shall deem materials as pass or fail following DHHS review.

5.1.1.9.2 The MCO shall complete and submit a DHHS-developed attestation that attests that the policy, procedure or other documentation satisfies all applicable State and federal authorities.

5.1.1.9.3 DHHS may require modifications to MCO policies and procedures or other documentation at any time as determined by DHHS.

5.1.2 Requirements for Waiver Programs

5.1.2.1 The MCO shall provide to DHHS the data and information required for its current CMS waiver programs and any waiver programs it enters during the Term of this Agreement that require data for Members covered by the MCO. These include but are not limited to:

5.1.2.1.1 NH's Building Capacity for Transformation 1115 waiver;

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5.1.2.1.2 [Amendment #8:] Substance Use Disorder and Severe Mental Illness Institute for Mental Disease 1115 waivers (subject to CMS approval);

5.1.2.1.3 Mandatory managed care 1915b waiver; and

5.1.2.1.4 Granite Advantage 1115 waiver.

5.1.3 Encounter Data

5.1.3.1 The MCO shall submit Encounter Data in the format and content, timeliness, completeness, and accuracy as specified by DHHS and in accordance with timeliness, completeness, and accuracy standards as established by DHHS. [42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818]

5.1.3.2 All MCO encounter requirements apply to all Subcontractors. The MCO shall ensure that all contracts with Participating Providers and Subcontractors contain provisions that require all encounter records are reported or submitted in an accurate and timely fashion such that the MCO meets all DHHS reporting requirements.

5.1.3.3 The MCO shall submit to DHHS for review, during the Readiness Review process, its policies and procedures that detail the MCO's encounter process. The MCO-submitted policies and procedures shall at minimum include to DHHS's satisfaction:

5.1.3.3.1 An end-to-end description of the MCO's encounter process;

5.1.3.3.2 A detailed overview of the encounter process with all Providers and Subcontractors; and

5.1.3.3.3 A detailed description of the internal reconciliation process followed by the MCO, and all Subcontractors that process claims on the MCO's behalf.

5.1.3.4 The MCO shall, as requested by DHHS, submit updates to and revise upon request its policies and procedures that detail the MCO's encounter process.

5.1.3.5 All Encounter Data shall remain the property of DHHS and DHHS retains the right to use it for any purpose it deems necessary.

5.1.3.6 The MCO shall submit Encounter Data to the EQRO and DHHS in accordance with this Section 5.1.3 (Encounter Data) of the Agreement and to DHHS's actuaries, as requested, according to the format and specification of the actuaries.

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5.1.3.7 Submission of Encounter Data to DHHS does not eliminate the MCO's responsibility to comply with NHID rules, Chapter Ins 4000 Uniform Reporting System for Health Care Claims Data Sets.

5.1.3.8 The MCO shall ensure that encounter records are consistent with DHHS requirements and all applicable State and federal laws.

5.1.3.9 MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

5.1.3.10 The level of detail associated with encounters from Providers with whom the MCO has a capitated payment arrangement shall be the equivalent to the level of detail associated with encounters for which the MCO received and settled a FFS claim.

5.1.3.11 The MCO shall maintain a record of all information submitted by Providers on claims. All Provider-submitted claim information shall be submitted in the MCO's encounter records.

5.1.3.12 The MCO shall have a computer and data processing system, and staff, sufficient to accurately produce the data, reports, and encounter-record set in formats and timelines as defined in this Agreement.

5.1.3.13 The system shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

5.1.3.14 The MCO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these data in a standardized format approved by DHHS.

5.1.3.15 The MCO shall make all collected data available to DHHS after it is tested for compliance, accuracy, completeness, logic, and consistency.

5.1.3.16 The MCO's systems that are required to use or otherwise contain the applicable data type shall conform to current and future HIPAA-based standard code sets; the processes through which the data are generated shall conform to the same standards, including application of:

5.1.3.16.1 Health Care Common Procedure Coding System (HCPCS);

5.1.3.16.2 CPT codes;

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5.1.3.16.3 International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM and International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS;

5.1.3.16.4 National Drug Codes which is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. It is maintained and distributed by HHS, in collaboration with drug manufacturers;

5.1.3.16.5 Code on Dental Procedures and Nomenclature (CDT) which is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA);

5.1.3.16.6 POS Codes which are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry;

5.1.3.16.7 Claim Adjustment Reason Codes (CARC) which explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the Provider or the patient when other insurance is involved; and

5.1.3.16.8 Reason and Remark Codes (RARC) which are used when other insurance denial information is submitted to the MMIS using standard codes defined and maintained by CMS and the NCPDP.

5.1.3.17 All MCO encounters shall be submitted electronically to DHHS or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) or at the discretion of DHHS the ANSI X12N 837 post adjudicated transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NH file format, and other proprietary file layouts as defined by DHHS.

5.1.3.18 All MCO encounters shall be submitted with MCO paid amount, or FFS equivalent, and, as applicable, the Medicare paid amount, other insurance paid amount and/or expected Member Copayment amount.

5.1.3.19 [Amendment #5:] The paid amount (or FFS equivalent) submitted with Encounter Data shall be the amount paid to Providers, not the amount paid to MCO Subcontractors or Providers of shared services within the MCO's organization, third party administrators, or capitated entities. This requirement means that, for example for pharmacy claims, the MCO paid amount shall include the amount

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paid to the pharmacy and exclude any and all fees paid by the MCO to the Pharmacy Benefit Manager. The amount paid to the MCO's PBM is not acceptable.

5.1.3.20 The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

5.1.3.21 The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

5.1.3.22 The MCO shall collect, and submit to the State's fiscal agent, Member service level Encounter Data for all Covered Services.

5.1.3.23 The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

5.1.3.24 The MCO shall conform to all current and future HIPAA-compliant standards for information exchange, including but not limited to the following requirements:

5.1.3.24.1 Batch and Online Transaction Types are as follows:

5.1.3.24.1.1. ASC X12N 820 Premium Payment Transaction;

5.1.3.24.1.2. ASC X12N 834 Enrollment and Audit Transaction;

5.1.3.24.1.3. ASC X12N 835 Claims Payment Remittance Advice Transaction;

5.1.3.24.1.4. ASC X12N 837I Institutional Claim/Encounter Transaction;

5.1.3.24.1.5. ASC X12N 837P Professional Claim/Encounter Transaction;

5.1.3.24.1.6. ASC X12N 837D Dental Claim/Encounter Transaction; and

5.1.3.24.1.7. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.24.2 Online transaction types are as follows:

5.1.3.24.2.1. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

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- 5.1.3.24.2.2. ASC X12N 276 Claims Status Inquiry;
- 5.1.3.24.2.3. ASC X12N 277 Claims Status Response;
- 5.1.3.24.2.4. ASC X12N 278/279 Utilization Review Inquiry/Response; and
- 5.1.3.24.2.5. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.25 Submitted Encounter Data shall include all elements specified by DHHS, including but not limited to those specified in the DHHS Medicaid Encounter Submission Requirements Policy.

5.1.3.26 The MCO shall submit summary reporting in accordance with Exhibit O, to be used to validate Encounter submissions.

5.1.3.27 The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by DHHS for reporting Encounters and fee-for-service claims.

5.1.3.28 Any exceptions shall be considered on a code-by-code basis after DHHS receives written notice from the MCO requesting an exception.

5.1.3.29 The MCO shall use the Provider identifiers as directed by DHHS for both Encounter and FFS submissions, as applicable.

5.1.3.30 The MCO shall provide, as a supplement to the Encounter Data submission, a Member file on a monthly basis, which shall contain appropriate Member Medicaid identification numbers, the PCP assignment of each Member, and the group affiliation and service location address of the PCP.

5.1.3.31 The MCO shall submit complete Encounter Data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

5.1.3.32 The MCO shall assign staff to participate in encounter technical work group meetings as directed by DHHS.

5.1.3.33 The MCO shall provide complete and accurate encounters to DHHS.

5.1.3.34 The MCO shall implement review procedures to validate Encounter Data submitted by Providers. The MCO shall meet the following standards:

- 5.1.3.34.1 Completeness:

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5.1.3.34.1.1. The MCO shall submit encounters that represent one hundred percent (100%) of the Covered Services provided by Participating Providers and Non-Participating Providers.

5.1.3.34.2 Accuracy:

5.1.3.34.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits. The standard shall apply to submissions of each individual batch and online transaction type.

5.1.3.34.2.2. Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

5.1.3.34.2.3. One-hundred percent (100%) of Member identification numbers shall be accurate and valid.

5.1.3.34.2.4. Ninety-eight percent (98%) of billing Provider information shall be accurate and valid.

5.1.3.34.2.5. Ninety-eight percent (98%) of servicing Provider information shall be accurate and valid.

5.1.3.34.2.6. The MCO shall submit a monthly supplemental Provider file, to include data elements as defined by DHHS, for all Providers that were submitted on encounters in the prior month.

5.1.3.34.2.7. For the first six (6) months of encounter production submissions, the MCO shall conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Data quality.

5.1.3.34.2.7.1 The end to end test shall include a review of the Provider claim to what data is in the MCO claims processing system, and the encounter file record produced for that claim.

5.1.3.34.2.7.2 The MCO shall report a pass or fail to DHHS. If the result is a fail, the MCO shall also

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submit a root cause analysis that includes plans for remediation.

5.1.3.34.2.7.3 If DHHS or the MCO identifies a data defect, the MCO shall, for six (6) months post data defect identification, conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Data quality.

5.1.3.34.2.7.4 If two (2) or more Encounter Data defects are identified within a rolling twelve (12) month period, DHHS may require the MCO to contract with an external vendor to independently assess the MCO Encounter Data process. The external vendor shall produce a report that shall be shared with DHHS.

5.1.3.34.3 Timeliness:

5.1.3.34.3.1. Encounter Data shall be submitted weekly, within fourteen (14) calendar days of claim payment.

5.1.3.34.3.2. All encounters shall be submitted, both paid and denied claims.

5.1.3.34.3.3. The MCO shall be subject to liquidated damages as specified in Section 5.5.2 (Liquidated Damages) for failure to timely submit Encounter Data, in accordance with the accuracy standards established in this Agreement.

5.1.3.34.4 Error Resolution:

5.1.3.34.4.1. For all historical encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice.

5.1.3.34.4.2. For all ongoing claim encounters, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fourteen (14) calendar days after such notice.

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5.1.3.34.4.3. If the MCO fails to comply with either error resolution timeline, DHHS shall require a CAP and assess liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.3.34.4.4. The MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by DHHS.

5.1.3.34.5 Survival:

5.1.3.34.5.1. All Encounter Data accumulated as part of the MCM program shall remain the property of DHHS and, upon termination of the Agreement, the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS and as is further described in Section 7.7.2 (Data).

5.1.4 Data Certification

5.1.4.1 All data submitted to DHHS by the MCO shall be certified by one (1) of the following:

5.1.4.1.1 The MCO's CEO;

5.1.4.1.2 The MCO's CFO; or

5.1.4.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. [42 CFR 438.604; 42 CFR 438.606(a)]

5.1.4.2 The data that shall be certified include, but are not limited to, all documents specified by DHHS; enrollment information, Encounter Data, and other information contained in this Agreement or proposals.

5.1.4.3 The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data.

5.1.4.4 The MCO shall submit the certification concurrently with the certified data and documents [42 CFR 438.604; 42 CFR 438.606].

5.1.4.5 The MCO shall submit the MCO Data Certification process policies and procedures for DHHS review during the Readiness Review process.

5.1.5 Data System Support for Quality Assurance & Performance Improvement

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5.1.5.1 The MCO shall have a data collection, processing, and reporting system sufficient to support the QAPI program requirements described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

5.1.5.2 The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of Participating Providers, Member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

5.2 Contract Oversight Program

5.2.1 The MCO shall have a formalized Contract Oversight Program to ensure that it complies with this Agreement, which at a minimum, should outline:

5.2.1.1 The specific monitoring and auditing activities that the MCO shall undertake to ensure its and its Subcontractors' compliance with certain provisions and requirements of the Agreement;

5.2.1.2 The frequency of those contract oversight activities; and

5.2.1.3 The person(s) responsible for those contract oversight activities.

5.2.2 The Contract Oversight Program shall specifically address how the MCO shall oversee the MCO's and its Subcontractor's compliance with the following provisions and requirements of the Agreement:

5.2.2.1 Section 3.12 (Privacy and Security of Members' Information);

5.2.2.2 Section 3.14 (Subcontractors);

5.2.2.3 Section 4 (Program Requirements); and

5.2.2.4 All data and reporting requirements.

5.2.3 The Contract Oversight Program shall set forth how the MCO's Chief Executive Officer (CEO)/Executive Director, Compliance Officer and Board of Directors shall be made aware of non-compliance identified through the Contract Oversight Program.

5.2.4 The MCO shall present to DHHS for review as part of the Readiness Review a copy of the Contract Oversight Program and any implementing policies.

5.2.5 The MCO shall present to DHHS for review redlined copies of proposed changes to the Contract Oversight Program and its implementing policies prior to adoption.

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5.2.6 This Contract Oversight Program is distinct from the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan discussed in Section 5.3 (Program Integrity).

5.2.7 The MCO shall promptly, but no later than thirty (30) calendar days after the date of discovery, report any material non-compliance identified through the Contract Oversight Program and submit a Corrective Action Plan to DHHS to remediate such non-compliance.

5.2.8 The MCO shall implement any changes to the Corrective Action Plan requested by DHHS.

5.3 Program Integrity

5.3.1 General Requirements

5.3.1.1 The MCO shall present to DHHS for review, as part of the Readiness Review process, a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan and shall comply with policies and procedures that guide and require the MCO and the MCO's officers, employees, agents and Subcontractors to comply with the requirements of this Section 5.3 (Program Integrity). [42 CFR 438.608]

5.3.1.2 The MCO shall present to DHHS for review redlined copies of proposed changes to the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan prior to adoption.

5.3.1.3 The MCO shall include program integrity requirements in its Subcontracts and provider application, credentialing and recredentialing processes.

5.3.1.4 The MCO is expected to be familiar with, comply with, and require compliance by its Subcontractors with all regulations and sub-regulatory guidance related to program integrity whether or not those regulations are listed below:

5.3.1.4.1 Section 1902(a)(68) of the Social Security Act;

5.3.1.4.2 42 CFR Section 438;

5.3.1.4.3 42 CFR Section 455;

5.3.1.4.4 42 CFR Section 1000 through 1008; and

5.3.1.4.5 CMS Toolkits.

5.3.1.5 The MCO shall ensure compliance with the program integrity provisions of this Agreement, including proper payments to providers or Subcontractors, methods for detection and prevention of

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fraud, waste and abuse and the MCO's and its Subcontractors' compliance with all program integrity reporting requirements to DHHS.

5.3.1.6 The MCO shall have a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan that are designed to guard against fraud, waste and abuse.

5.3.1.7 The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent and deter fraud, waste and abuse.

5.3.1.8 The MCO shall be compliant with all applicable federal and State regulations related to Medicaid program integrity. [42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008 and Section 1902(a)(68) of the Social Security Act]

5.3.1.9 The MCO shall work with DHHS on program integrity issues, and with MFCU as directed by DHHS, on fraud, waste or abuse investigations. This shall include, at a minimum, the following:

5.3.1.9.1 Participation in MCO program integrity meetings with DHHS following the submission of the monthly allegation log submitted by the MCO in accordance with Exhibit O.

5.3.1.9.2 The frequency of the program integrity meetings shall be as often as monthly.

5.3.1.9.3 Discussion at these meetings shall include, but not be limited to, case development and monitoring.

5.3.1.9.4 The MCO shall ensure Subcontractors attend monthly meetings when requested by DHHS;

5.3.1.9.5 Participation in bi-annual MCO and Subcontractor forums to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned;

5.3.1.9.6 Quality control and review of encounter data submitted to DHHS; and

5.3.1.9.7 Participation in meetings with MFCU, as determined by MFCU and DHHS.

5.3.2 Fraud, Waste and Abuse

5.3.2.1 The MCO, or a Subcontractor which has been delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain administrative and

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management arrangements or procedures designed to detect and prevent fraud, waste and abuse. [42 CFR 438.608(a)]

5.3.2.2 The arrangements or procedures shall include the following:

5.3.2.2.1 The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan that includes, at a minimum, all of the following elements:

5.3.2.2.1.1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable federal and State requirements;

5.3.2.2.1.2. Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the Agreement and who directly reports to the CEO and the Board of Directors;

5.3.2.2.1.3. Establishment of a Regulatory Compliance Committee of the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with this Agreement;

5.3.2.2.1.4. System for training and education for the Compliance Officer, the MCO's senior management, employees, and Subcontractor on the federal and State standards and requirements under this Agreement;

5.3.2.2.1.5. Effective lines of communication between the Compliance Officer and MCO's staff and Subcontractors;

5.3.2.2.1.6. Enforcement of standards through well-publicized disciplinary guidelines; and

5.3.2.2.1.7. Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination

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of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement. [42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i) - (vii)]

5.3.2.2.2 The process by which the MCO shall monitor their marketing representative activities to ensure that the MCO does not engage in inappropriate activities, such as inducements;

5.3.2.2.3 A requirement that the MCO shall report on staff termination for engaging in prohibited marketing conduct or fraud, waste and abuse to DHHS within thirty (30) business days;

5.3.2.2.4 A description of the MCO's specific controls to detect and prevent potential fraud, waste and abuse including, without limitation:

5.3.2.2.4.1. A list of automated pre-payment claims edits, including National Correct Coding Initiative (NCCI) edits;

5.3.2.2.4.2. A list of automated post-payment claims edits;

5.3.2.2.4.3. In accordance with 42 CFR 438.602(b), the MCO shall maintain edits on its claims systems to ensure in-network claims include New Hampshire Medicaid enrolled billing and rendering provider NPIs. The MCO shall amend edits on its claims systems as required by any changes in federal and State requirements for managed care billing;

5.3.2.2.4.4. At least three (3) data analytic algorithms for fraud detection specified by DHHS Program Integrity and three (3) additional data analytic algorithms as determined by the MCO for a total of at least six (6) algorithms, which should include services provided by Subcontractors. These algorithms are subject to change at least annually;

5.3.2.2.4.5. A list of audits of post-processing review of claims planned;

5.3.2.2.4.6. A list of reports on Participating Provider and Non-Participating Provider profiling used to aid program integrity reviews;

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5.3.2.2.4.7. The methods the MCO shall use to identify high-risk claims and the MCO's definition of "high-risk claims";

5.3.2.2.4.8. Visit verification procedures and practices, including sample sizes and targeted provider types or locations;

5.3.2.2.4.9. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

5.3.2.2.4.10. A method to verify, by sampling or other method, whether services that have been represented to have been delivered by Participating Providers and were received by Members and the application of such verification processes on a regular basis. The MCO may use an explanation of benefits (EOB) for such verification only if the MCO suppresses information on EOBs that would be a violation of Member confidentiality requirements for women's health care, family planning, sexually transmitted diseases, and behavioral health services [42 CFR 455.20];

5.3.2.2.4.11. Provider and Member materials identifying the MCO's fraud and abuse reporting hotline number;

5.3.2.2.4.12. Work plans for conducting both announced and unannounced site visits and field audits of Participating Providers determined to be at high risk to ensure services are rendered and billed correctly;

5.3.2.2.4.13. The process for putting a Participating Provider on and taking a Participating Provider off prepayment review, including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate;

5.3.2.2.4.14. The ability to suspend a Participating Provider's or Non-Participating Provider's payment due to credible allegation of fraud if directed by DHHS Program Integrity; and

5.3.2.2.4.15. The process by which the MCO shall recover inappropriately paid funds if the MCO discovers wasteful and/or abusive, incorrect billing trends with a

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particular Participating Provider or provider type, specific billing issue trends, or quality trends.

5.3.2.2.5 A provision for the prompt reporting of all Overpayments identified and recovered, specifying the Overpayments due to potential fraud;

5.3.2.2.6 A provision for referral of any potential Participating Provider or Non-Participating Provider fraud, waste and abuse that the MCO or Subcontractor identifies to DHHS Program Integrity and any potential fraud directly to the MFCU as required under this Agreement [42 CFR 438.608(a)(7)];

5.3.2.2.7 A provision for the MCO's suspension of payments to a Participating Provider for which DHHS determines there is credible allegation of fraud in accordance with this Agreement and 42 CFR 455.23; and

5.3.2.2.8 A provision for notification to DHHS when the MCO receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the MCM program, including the termination of the provider agreement with the MCO as detailed in Exhibit O.

5.3.2.3 The MCO and Subcontractors shall implement and maintain written policies for all employees and any Subcontractor or agent of the entity, that provide detailed information about the False Claims Act (FCA) and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Social Security Act; 42 CFR 438.608(a)(6)]

5.3.2.4 The MCO, and if required by the MCO's Subcontractors, shall post and maintain DHHS-approved information related to fraud, waste and abuse on its website, including but not limited to, provider notices, current listing of Participating Providers, providers that have been excluded or sanctioned from the Medicaid Care Management Program, any updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

5.3.3 Identification and Recoveries of Overpayments

5.3.3.1 The MCO shall maintain an effective fraud, waste and abuse-related Provider overpayment identification, Recovery and tracking process.

5.3.3.2 The MCO shall perform ongoing analysis of its authorization, utilization, claims, Provider's billing patterns, and

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encounter data to detect improper payments, and shall perform audits and investigations of Subcontractors, Providers and Provider entities.

5.3.3.3 This process shall include a methodology for a means of estimating overpayment, a formal process for documenting communication with Providers, and a system for managing and tracking of investigation findings, Recoveries, and underpayments related to fraud, waste and abuse investigations/audit/any other overpayment recovery process as described in the fraud, waste and abuse reports provided to DHHS in accordance with Exhibit O.

5.3.3.4 The MCO and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all Overpayments, specifically for the recovery of Overpayments due to fraud, waste and abuse, and for reporting and returning Overpayments as required by this Agreement. [42 CFR 438.608(d)(1)(i)]

5.3.3.5 The MCO and its subcontractors shall report to DHHS within sixty (60) calendar days when it has identified Capitation Payments or other payment amounts received are in excess to the amounts specified in this Agreement. [42 CFR 438.608(c)(3)].

5.3.3.6 DHHS may recover Overpayments that are not recovered by or returned to the MCO within sixty (60) calendar days of notification by DHHS to pursue.

5.3.3.7 This Section of the Agreement does not apply to any amount of a recovery to be retained under False Claim Act cases or through other investigations.

5.3.3.8 Any settlement reached by the MCO or its subcontractors and a Provider shall not bind or preclude the State from further action.

5.3.3.9 DHHS shall utilize the information and documentation collected under this Agreement, as well as nationally recognized information on average recovery amounts as reported by State MFCUs and commercial insurance plans for setting actuarially sound Capitation Payments for each MCO consistent with the requirements in 42 CFR 438.4.

5.3.3.10 If the MCO does not meet the required metrics related to expected fraud referrals, overpayment recoupments, and other measures set forth in this Agreement and Exhibit O, DHHS shall impose liquidated damages, unless the MCO can demonstrate good cause for failure to meet such metrics.

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5.3.4 Referrals of Credible Allegations of Fraud and Provider and Payment Suspensions

5.3.4.1 General

5.3.4.1.1 The MCO shall, and shall require any Subcontractor to, establish policies and procedures for referrals to DHHS Program Integrity Unit and the MFCU on credible allegations of fraud and for payment suspension when there is a credible allegation of fraud. [42 CFR 438.608(a)(8); 42 CFR 455.23].

5.3.4.1.2 The MCO shall complete a DHHS "Request to Open" form for any potential fraud, waste, or abuse case, including those that lead to a credible allegation of fraud. DHHS Program Integrity Unit shall have fifteen (15) business days to respond to the MCO's "Request to Open" form.

5.3.4.1.3 When the MCO or its Subcontractor has concluded that a credible allegation of fraud or abuse exists, the MCO shall make a referral to DHHS Program Integrity Unit and any potential fraud directly to MFCU within five (5) business days of the determination on a template provided by DHHS. [42 CFR 438.608(a)(7)]

5.3.4.1.4 Unless and until prior written approval is obtained from DHHS, neither the MCO nor a Subcontractor shall take any administrative action or any of the following regarding the allegations of suspected fraud:

5.3.4.1.4.1. Suspend Provider payments;

5.3.4.1.4.2. Contact the subject of the investigation about any matters related to the investigation;

5.3.4.1.4.3. Continue the investigation into the matter;

5.3.4.1.4.4. Enter into or attempt to negotiate any settlement or agreement regarding the matter; or

5.3.4.1.4.5. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

5.3.4.1.5 The MCO shall employ pre-payment review when directed by DHHS.

5.3.4.1.6 In addition, the MCO may employ pre-payment review in the following circumstances without approval:

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- 5.3.4.1.6.1. Upon new Participating Provider enrollment;
 - 5.3.4.1.6.2. For delayed payment during Provider education;
 - 5.3.4.1.6.3. For existing Providers with billing inaccuracies;
 - 5.3.4.1.6.4. Upon receipt of a credible allegation of fraud or abuse; or
 - 5.3.4.1.6.5. Upon identification from data analysis or other grounds.
- 5.3.4.1.7 If DHHS, MFCU or another law enforcement agency accepts the allegation for investigation, DHHS shall notify the MCO's Compliance Officer within two (2) business days of the acceptance notification, along with a directive to suspend payment to the affected Provider(s) if it is determined that suspension shall not impair MFCU's or law enforcement's investigation.
- 5.3.4.1.8 DHHS shall notify the MCO if the referral is declined for investigation.
- 5.3.4.1.9 If DHHS, MFCU, or other law enforcement agencies decline to investigate the fraud referral, the MCO may proceed with its own investigation and comply with the reporting requirements contained in this Section of the Agreement.
- 5.3.4.1.10 Upon receipt of notification from DHHS, the MCO shall send notice of the decision to suspend program payments to the Provider within the following timeframe:
- 5.3.4.1.10.1. Within five (5) calendar days of taking such action unless requested in writing by DHHS, the MFCU, or law enforcement to temporarily withhold such notice; or
 - 5.3.4.1.10.2. Within thirty (30) calendar days if requested by DHHS, MFCU, or law enforcement in writing to delay sending such notice.
 - 5.3.4.1.10.3. The request for delay may be renewed in writing no more than twice and in no event may the delay exceed ninety (90) calendar days.
- 5.3.4.1.11 The notice shall include or address all of the following (42 CFR 455.23(2)):

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5.3.4.1.11.1. That payments are being suspended in accordance with this provision;

5.3.4.1.11.2. Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation;

5.3.4.1.11.3. That the suspension is for a temporary period and cite the circumstances under which the suspension shall be lifted;

5.3.4.1.11.4. Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

5.3.4.1.11.5. Where applicable and appropriate, inform the Provider of any appeal rights available to the Provider, along with the Provider's right to submit written evidence for consideration by the MCO.

5.3.4.2 All suspension of payment actions under this Section of the Agreement shall be temporary and shall not continue after either of the following:

5.3.4.2.1 The MCO is notified by DHHS that there is insufficient evidence of fraud by the Provider; or

5.3.4.2.2 The MCO is notified by DHHS that the legal proceedings related to the Provider's alleged fraud are completed.

5.3.4.3 The MCO shall document in writing the termination of a payment suspension and issue a notice of the termination to the Provider and to DHHS.

5.3.4.4 The DHHS Program Integrity Unit may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

5.3.4.4.1 MFCU or other law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;

5.3.4.4.2 Other available remedies are available to the MCO, after DHHS approves the remedies that more effectively or quickly protect Medicaid funds;

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5.3.4.4.3 The MCO determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, there is no longer a credible allegation of fraud and that the suspension should be removed.

5.3.4.4.3.1. The MCO shall review evidence submitted by the Provider and submit it with a recommendation to DHHS.

5.3.4.4.3.2. DHHS shall direct the MCO to continue, reduce or remove the payment suspension within thirty (30) calendar days of having received the evidence;

5.3.4.4.4 Member access to items or services would be jeopardized by a payment suspension because of either of the following:

5.3.4.4.4.1. An individual or entity is the sole community physician or the sole source of essential specialized services in a community; or

5.3.4.4.4.2. The individual or entity serves a large number of Members within a federal HRSA designated a medically underserved area;

5.3.4.4.5 MFCU or law enforcement declines to certify that a matter continues to be under investigation; or

5.3.4.4.6 DHHS determines that payment suspension is not in the best interests of the Medicaid program.

5.3.4.5 The MCO shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

5.3.4.5.1 Details of payment suspensions that were imposed in whole or in part; and

5.3.4.5.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.

5.3.4.6 If the MCO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of fraud without good cause, and DHHS directed the MCO to suspend payments, DHHS may impose liquidated damages.

5.3.4.7 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery

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belongs exclusively to the State, and the MCO and any involved Subcontractor have no claim to any portion of such recovery.

5.3.4.8 Furthermore, the MCO is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the State for all criminal, civil and administrative action recoveries undertaken by any government entity, including but not limited to all claims the MCO or its Subcontractor(s) has or may have against any entity or individual that directly or indirectly receives funds under this Agreement, including but not limited to any health care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other Provider in the design, manufacture, Marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DME, or other health care related products or services.

5.3.4.8.1 For the purposes of this Section of the Agreement, "subrogation" means the right of any State government entity or local law enforcement to stand in the place of the MCO or client in the collection against a third party.

5.3.4.9 Any funds recovered and retained by a government entity shall be reported to the actuary to consider in the rate-setting process.

5.3.5 Investigations

5.3.5.1 The MCO and its Subcontractors shall cooperate with all State and federal agencies that investigate fraud, waste and abuse.

5.3.5.2 The MCO shall ensure its Subcontractors and any other contracted entities are contractually required to also participate fully with any State or federal agency or their contractors.

5.3.5.3 The MCO and its Subcontractors shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable State or federal agency (e.g., MFCU, DHHS, OIG, and CMS).

5.3.5.4 The MCO and its Subcontractors shall comply with any and all directives resulting from State or federal agency investigations.

5.3.5.5 The MCO and its Subcontractors shall maintain all records, documents and claim or encounter data for Members, Providers and Subcontractors who are under investigation by any State or federal agency in accordance with retention rules or until the investigation is complete and the case is closed by the investigating State or federal agency.

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5.3.5.6 The MCO shall provide any data access or detail records upon written request from DHHS for any potential fraud, waste and abuse investigation, Provider or claim audit, or for MCO oversight review.

5.3.5.6.1 The additional access shall be provided within three (3) business days of the request.

5.3.5.7 The MCO and its Subcontractors shall request a refund from a third-party payor, Provider or Subcontractor when an investigation indicates that such a refund is due.

5.3.5.7.1 These refunds shall be reported to DHHS as Overpayments.

5.3.5.8 DHHS shall conduct investigations related to suspected Provider fraud, waste and abuse cases, and reserves the right to pursue and retain recoveries for all claims (regardless of paid date) to a Provider with a paid date older than four (4) months for which the MCO has not submitted a request to open and for which the MCO continued to pursue the case. The State shall notify the MCO of any investigation it intends to open prior to contacting the Provider.

5.3.6 Reporting

5.3.6.1 Annual Fraud Prevention Report

5.3.6.1.1 The MCO shall submit an annual summary (the "Fraud Prevention Report") that shall document the outcome and scope of the activities performed under Section 5.3 (Program Integrity).

5.3.6.1.2 The annual Fraud Prevention summary shall include, at a minimum, the following elements, in accordance with Exhibit O:

5.3.6.1.2.1. The name of the person and department responsible for submitting the Fraud Prevention Report;

5.3.6.1.2.2. The date the report was prepared;

5.3.6.1.2.3. The date the report is submitted;

5.3.6.1.2.4. A description of the SIU;

5.3.6.1.2.5. Cumulative Overpayments identified and recovered;

5.3.6.1.2.6. Investigations initiated, completed, and referred;

5.3.6.1.2.7. Analysis of the effectiveness of the activities performed; and

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5.3.6.1.2.8. Other information in accordance with Exhibit O.

5.3.6.1.3 As part of this report, the MCO shall submit to DHHS the Overpayments it recovered, certified by its CFO that this information is accurate to the best of his or her information, knowledge, and belief, as required by Exhibit O. [42 CFR 438.606]

5.3.6.2 Reporting Member Fraud

5.3.6.2.1 The MCO shall notify DHHS of any cases in which the MCO believes there is a serious likelihood of Member fraud by sending a secure email to the DHHS Special Investigation Unit.

5.3.6.2.2 The MCO is responsible for investigating Member fraud, waste and abuse and referring Member fraud to DHHS. The MCO shall provide initial allegations, investigations and resolutions of Member fraud to DHHS.

5.3.6.3 Termination Report

5.3.6.3.1 The MCO shall submit to DHHS a monthly Termination Report including Providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related program integrity involuntary termination; Provider terminations for convenience; and Providers who self-terminated.

5.3.6.3.2 The report shall be completed using the DHHS template.

5.3.6.4 Other Reports

5.3.6.4.1 The MCO shall submit to DHHS demographic changes that may impact eligibility (e.g., Address, etc.).

5.3.6.4.2 The MCO shall report at least annually to DHHS, and as otherwise required by this Agreement, on their recoveries of Overpayments. [42 CFR 38.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)]

5.3.7 Access to Records, On-Site Inspections and Periodic Audits

5.3.7.1 As an integral part of the MCO's program integrity function, and in accordance with 42 CFR 455 and 42 CFR 438, the MCO shall provide DHHS program integrity staff (or its designee), real time access to all of the MCO electronic encounter and claims data (including DHHS third-party liability) from the MCO's current claims reporting system.

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5.3.7.2 The MCO shall provide DHHS with the capability to access accurate, timely, and complete data as specified in Section 4.18.2 (Claims Quality Assurance Program).

5.3.7.3 [Amendment #10:] ~~Upon request,~~ The MCO and the MCO's Providers and Subcontractors shall permit DHHS, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises at any time during normal business hours to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours.

5.3.7.4 The MCO and its Providers and Subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring or evaluation.

5.3.7.5 Copies of records and documents shall be made at no cost to the requesting agency. [42 CFR 438.3(h)]; 42 CFR 455.21(a)(2); 42 CFR 431.107(b)(2)]. A record includes, but is not limited to:

5.3.7.5.1 Medical records;

5.3.7.5.2 Billing records;

5.3.7.5.3 Financial records;

5.3.7.5.4 Any record related to services rendered, and quality, appropriateness, and timeliness of such service;

5.3.7.5.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and

5.3.7.5.6 Any record of an MCO-paid claim or encounter, or an MCO-denied claim or encounter.

5.3.7.6 Upon request, the MCO, its Provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate DHHS, MFCU or other State or federal agencies.

5.3.7.7 DHHS, CMS, MFCU, the OIG, the Comptroller General, or any other authorized State or federal agency or duly authorized representative shall be permitted to inspect the premises, physical

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facilities, and equipment where Medicaid-related activities are conducted at any time. [42 CFR 438.3(h)]

5.3.7.8 The MCO and its Subcontractors shall be subject to on-site or offsite reviews by DHHS and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests.

5.3.7.8.1 Documents shall be furnished by the MCO or its Subcontractors at the MCO's expense.

5.3.7.9 The right to inspect and audit any records or documents of the MCO or any Subcontractor shall extend for a period of ten (10) years from the final date of this Agreement's contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.3.7.10 DHHS shall conduct, or contract for the conducting of, periodic audits of the MCO no less frequently than once every three (3) years, for the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO. [42 CFR 438.602(e)]

5.3.7.10.1 This shall include, but not be limited to, any records relevant to the MCO's obligation to bear the risk of financial losses or services performed or payable amounts under the Agreement.

5.3.8 Transparency

5.3.8.1 DHHS shall post on its website, as required by 42 CFR 438.10(c)(3), the following documents and reports:

5.3.8.1.1 The Agreement;

5.3.8.1.2 The data at 42 CFR 438.604(a)(5) where DHHS certifies that the MCO has complied with the Agreement requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 CFR 438.206;

5.3.8.1.3 The name and title of individuals included in 42 CFR 438.604(a)(6) to confirm ownership and control of the MCO, described in 42 CFR 455.104, and Subcontractors as governed by 42 CFR 438.230;

5.3.8.1.4 The results of any audits, under 42 CFR 438.602(e), and the accuracy, truthfulness, and completeness of the encounter and financial data submitted and certified by MCO; and

5.3.8.1.5 Performance metrics and outcomes.

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5.4 MCM Withhold and Incentive Program

5.4.1 [Amendment #3:] Beginning July 1, 2020, DHHS shall institute a withhold arrangement through which an actuarially sound percentage of the MCO's risk adjusted Capitation Payment will be recouped from the MCO and distributed among the MCOs participating in the MCM program on the basis of meeting targets specified in the DHHS Withhold and Incentive Program Policy.

5.4.1.1 [Amendment #3:] For the September 2019 to June 2020 contract year, DHHS shall waive the quality withhold provisions of the Agreement due to the impact of the COVID-19 Public Health Emergency. All MCOs shall receive 100% of the quality withhold.

5.4.2 [Amendment #5:] DHHS shall issue MCM Withhold and Incentive Program Guidance by August 1st each year and/or at other times as determined by DHHS. ~~[Amendment #4:] DHHS shall, as often as annually, issue MCM Withhold and Incentive Program Guidance within ninety (90) calendar days of the start of the Plan Year, by August 1st each year.~~

5.4.3 Pursuant to 42 CFR 438.6 (b)(3), this withhold arrangement shall :

5.4.3.1 [Amendment #5:] Intentionally left blank.

5.4.3.1.1 Be for a fixed period of time and performance is measured during the rating period under the Agreement in which the withhold arrangement is applied;

5.4.3.1.2 Not be renewed automatically;

5.4.3.1.3 Be made available to both public and private contractors under the same terms of performance;

5.4.3.1.4 Not condition MCO participation in the withhold arrangement on the MCO entering into or adhering to intergovernmental transfer agreements; and

5.4.3.1.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.3.2 The MCO shall not receive incentive payments in excess of five percent (5%) of the approved Capitation Payments attributable to the Members or services covered by the incentive arrangements.

5.4.3.3 Pursuant to 42 CFR 438.6(b)(2), this incentive arrangement shall:

5.4.3.3.1 Be for a fixed period of time and performance is measured during the rating period under the Agreement in which the withhold arrangement is applied;

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5.4.3.3.2 Not be renewed automatically;

5.4.3.3.3 Be made available to both public and private contractors under the same terms of performance;

5.4.3.3.4 Not condition MCO participation in the incentive arrangement on the MCO entering into or adhering to intergovernmental transfer Agreements; and

5.4.3.3.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.4 [Amendment #4:] Any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period.

5.4.4.1 [Amendment #9:] [Amendment #8:] Intentionally left blank. Insofar as the withhold incentive is capped at one hundred five percent (105%) of approved Capitation Payments, and the design of the Withhold and Incentive Program is to maintain withhold funds in the program, should there be a remaining amount in withhold funds within the program, additional incentives shall be available through performance metrics determined by the State so that all funds will be disbursed before the end of the contract term in accordance with separate guidance.

5.4.5 [Amendment #9:] [Amendment #8:] Insofar as the withhold incentive is capped at one hundred five percent (105%) of approved Capitation Payments, and the design of the Withhold and Incentive Program is to maintain withhold funds in the program for actuarial soundness, should there be a remaining amount in withhold funds within the program, additional incentives shall be available through performance metrics determined by the State so that all funds will be disbursed before the end of the contract term in accordance with separate guidance.

5.4.5.1 [Amendment #9:] Such incentives may include performance of activities in support of the Department's efforts to manage Member medical assistance eligibility redeterminations tied to the COVID-19 Public Health Emergency.

5.4.5.1.1 [Amendment #9:] [Amendment #8:] 4.10.8.1.4 The MCO shall be eligible for a SFY 2023 withhold capitation credit up to one-half percent (.5%) based on Members who have completed their redeterminations between July 1, 2022 through December 31, 2022 as described in the MCM Withhold and Incentive Program Guidance.

5.4.5.1.2 [Amendment #9:] The MCO shall be eligible for a maximum withhold capitation credit for the SFY 2023 period up to one-half percent (.5%) based on Members who have completed their

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redeterminations between January 1, 2023 through June 30, 2023 as described in the MCM Withhold and Incentive Guidance.

5.4.5.1.2.1. [Amendment #10:] The MCO shall be eligible for a maximum withhold capitation credit for the July 1, 2023 through August 31, 2024 rating period up to 0.15% based on Members who have completed their redeterminations between July 1, 2023 through October 31, 2023 as described in the MCM Withhold and Incentive Guidance.

5.4.5.1.3 [Amendment #9:] The MCO shall be eligible for additional monetary incentives from unearned withhold related to the plan's COVID-19 Public Health Emergency Member redetermination efforts as described in the MCM Withhold and Incentive Program Guidance.

5.4.5.2 [Amendment #10:] The MCO may be eligible for additional monetary incentives from the unearned withhold funds related to performance of activities to enhance care management and administrative practices including, but not limited to: fraud, waste, and abuse; medication reviews; polypharmacy; substance use disorder; and opioid treatment provider oversight and compliance as described in separate guidance.

5.5 Remedies

5.5.1 **Reservation of Rights and Remedies**

5.5.1.1 The Parties acknowledge and agree that a material default or breach in this Agreement shall cause irreparable injury to DHHS.

5.5.1.2 The MCO acknowledges that failure to comply with provisions of this Agreement may, at DHHS's sole discretion, result in the assessment of liquidated damages, termination of the Agreement in whole or in part, and/or imposition of other sanctions as set forth in this Agreement and as otherwise available under State and federal law.

5.5.1.3 In the event of any claim for default or breach of this Agreement, no provision of this Agreement shall be construed, expressly or by implication, as a waiver by the State to any existing or future right or remedy available by law.

5.5.1.4 Failure of the State to insist upon the strict performance of any term or condition of this Agreement or to exercise or delay the exercise of any right or remedy provided in the Agreement or by law, or the acceptance of (or payment for) materials, equipment or

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services, shall not release the MCO from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State to insist upon the strict performance of this Agreement.

5.5.1.5 In addition to any other remedies that may be available for default or breach of the Agreement, in equity or otherwise, the State may seek injunctive relief against any threatened or actual breach of this Agreement without the necessity of proving actual damages.

5.5.1.6 The State reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as a result of any threatened or actual breach.

5.5.1.7 The remedies specified in this Section of the Agreement shall apply until the failure is cured or a resulting dispute is resolved in the MCO's favor.

5.5.2 Liquidated Damages

5.5.2.1 DHHS may perform an annual review to assess if the liquidated damages set forth in Exhibit N (Liquidated Damages Matrix) align with actual damages and/or with DHHS's strategic aims and areas of identified non-compliance, and update Exhibit N (Liquidated Damages Matrix) as needed.

5.5.2.2 DHHS and the MCO agree that it shall be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event the MCO fails to maintain the required performance standards within this Section during this Agreement.

5.5.2.3 The parties agree that the liquidated damages as specified in this Agreement and set forth in Exhibit N, and as updated by DHHS, are reasonable.

5.5.2.4 Assessment of liquidated damages shall be in addition to, not in lieu of, such other remedies that may be available to DHHS.

5.5.2.5 To the extent provided herein, DHHS shall be entitled to recover liquidated damages for each day, incidence or occurrence, as applicable, of a violation or failure.

5.5.2.6 The liquidated damages shall be assessed based on the categorization of the violation or non-compliance and are set forth in Exhibit N (Liquidated Damages Matrix).

5.5.2.7 The MCO shall be subject to liquidated damages for failure to comply in a timely manner with all reporting requirements in accordance with Exhibit O.

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5.5.3 Suspension of Payment

5.5.3.1 Payment of Capitation Payments may be suspended at DHHS's sole discretion when the MCO fails:

5.5.3.1.1 To cure a default under this Agreement to DHHS's satisfaction within thirty (30) calendar days of notification;

5.5.3.1.2 To implement a CAP addressing violations or non-compliance; and

5.5.3.1.3 To implement an approved Program Management Plan.

5.5.3.2 Upon correction of the deficiency or omission, Capitation Payments shall be reinstated.

5.5.4 Intermediate Sanctions

5.5.4.1 DHHS shall have the right to impose intermediate sanctions as set forth in 42 CFR Section 438.702(a), which include:

5.5.4.1.1 Civil monetary penalties (DHHS shall not impose any civil monetary penalty against the MCO in excess of the amounts set forth in 42 CFR 438.704(c), as adjusted);

5.5.4.1.2 Temporary management of the MCO;

5.5.4.1.3 Permitting Members to terminate enrollment without cause;

5.5.4.1.4 Suspending all new enrollment;

5.5.4.1.5 Suspending payments for new enrollment; and

5.5.4.1.6 Agreement termination.

5.5.4.2 DHHS shall impose intermediate sanctions if DHHS finds that the MCO acts or fails to act as follows:

5.5.4.2.1 Fails to substantially provide Medically Necessary services to a Member that the MCO is required to provide services to by law and/or under its Agreement with DHHS.

5.5.4.2.2 DHHS may impose a civil monetary penalty of up to \$25,000 for each failure to provide services, and may also:

5.5.4.2.2.1 Appoint temporary management for the MCO,

5.5.4.2.2.2 Grant Members the right to disenroll without cause,

5.5.4.2.2.3 Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies

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the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.2.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(1); 42 CFR 438.702(a); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.3 Imposes premiums or charges on Members that are in excess of those permitted in the Medicaid program, in which case, the State may impose a civil monetary of up to \$25,000 or double the amount of the excess charges (whichever is greater). The State may also:

5.5.4.2.3.1. Appoint temporary management to the MCO,

5.5.4.2.3.2. Grant Members the right to disenroll without cause,

5.5.4.2.3.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.3.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; [42 CFR 438.700(b)(2); 42 CFR 438.702(a); 42 CFR 438.704(c); sections 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii) of the Social Security Act]

5.5.4.2.4 Discriminates among Members on the basis of their health status or need for health services, in which case, DHHS may impose a civil monetary penalty of up to one hundred thousand dollars (\$100,000) for each determination by DHHS of discrimination. DHHS may impose a civil monetary penalty of up to fifteen thousand dollars (\$15,000) for each individual the MCO did not enroll because of a discriminatory practice, up to the one hundred thousand dollar (\$100,000) maximum. DHHS may also:

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- 5.5.4.2.4.1. Appoint temporary management to the MCO,
- 5.5.4.2.4.2. Grant Members the right to disenroll without cause,
- 5.5.4.2.4.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or
- 5.5.4.2.4.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(3); 42 CFR 438.702(a); 42 CFR 438.704(b)(2) and (3); sections 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii) & (iv) of the Social Security Act]
- 5.5.4.2.5 Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care Provider, in which case, DHHS may impose a civil monetary penalty of up to \$25,000 for each instance of misrepresentation. DHHS may also:
 - 5.5.4.2.5.1. Appoint temporary management to the MCO,
 - 5.5.4.2.5.2. Grant Members the right to disenroll without case,
 - 5.5.4.2.5.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or
 - 5.5.4.2.5.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]
- 5.5.4.2.6 Misrepresents or falsifies information that it furnishes to CMS or to DHHS, in which case, DHHS may impose a civil monetary

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penalty of up to one hundred thousand dollars (\$100,000) for each instance of misrepresentation. DHHS may also:

5.5.4.2.6.1. Appoint temporary management to the MCO,

5.5.4.2.6.2. Grant Members the right to disenroll without cause,

5.5.4.2.6.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.6.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.7 Fails to comply with the Medicare Physician Incentive Plan requirements, in which case, DHHS may impose a civil monetary penalty of up to \$25,000 for each failure to comply. DHHS may also:

5.5.4.2.7.1. Appoint temporary management to the MCO,

5.5.4.2.7.2. Grant Members the right to disenroll without cause,

5.5.4.2.7.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.7.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B);

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1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.3 DHHS shall have the right to impose civil monetary penalty of up to \$25,000 for each distribution if DHHS determines that the MCO has distributed directly, or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by DHHS or that contain false or materially misleading information. [42 CFR 438.700(c); 42 CFR 438.704(b)(1); sections 1932(e)(1)(A); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.4 DHHS shall have the right to terminate this Agreement and enroll the MCO's Members in other MCOs if DHHS determines that the MCO has failed to either carry out the terms of this Agreement or meet applicable requirements in Sections 1905(t), 1903(m), and 1905(t) 1932 of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]

5.5.4.5 DHHS shall grant Members the right to terminate MCO enrollment without cause when an MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438. [42 CFR 438.706(b) - (d); section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.4.6 DHHS shall only have the right to impose the following intermediate sanctions when DHHS determines that the MCO violated any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations:

5.5.4.6.1 Grant Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll immediately;

5.5.4.6.2 Provide notice to Members of DHHS's intent to terminate the Agreement;

5.5.4.6.3 Suspend all new enrollment, including default enrollment, after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act; and

5.5.4.6.4 Suspend payment for Members enrolled after the effective date of the sanction and until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

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5.5.4.6.5 [42 CFR 438.700; 42 CFR 438.702(a); 42 CFR 438.704; 42 CFR 438.706(b); 42 CFR 438.722(a)-(b); Sections 1903(m)(5); 1932(e) of the Social Security Act]

5.5.5 Administrative and Other Remedies

5.5.5.1 At its sole discretion, DHHS may, in addition to the other Remedies described within this Section 5.5 (Remedies), also impose the following remedies:

5.5.5.1.1 Requiring immediate remediation of any deficiency as determined by DHHS;

5.5.5.1.2 Requiring the submission of a CAP;

5.5.5.1.3 Suspending part of or all new enrollments;

5.5.5.1.4 Suspending part of the Agreement;

5.5.5.1.5 Requiring mandated trainings; and/or

5.5.5.1.6 Suspending all or part of Marketing activities for varying lengths of time.

5.5.5.2 Temporary Management

5.5.5.2.1 DHHS, at its sole discretion, shall impose temporary management when DHHS finds, through onsite surveys, Member or other complaints, financial status, or any other source:

5.5.5.2.1.1. There is continued egregious behavior by the MCO;

5.5.5.2.1.2. There is substantial risk to Members' health;

5.5.5.2.1.3. The sanction is necessary to ensure the health of the MCO's Members in one (1) of two (2) circumstances: while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the MCO. [42 CFR 438.706(a); section 1932(e)(2)(B)(i) of the Social Security Act]

5.5.5.2.2 DHHS shall impose mandatory temporary management when the MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438.

5.5.5.2.3 DHHS shall not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines, in its sole discretion, that the MCO

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can ensure the sanctioned behavior shall not reoccur. [42 CFR 438.706(b)-(d); Section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.6 Corrective Action Plan

5.5.6.1 If requested by DHHS, the MCO shall submit a CAP within five (5) business days of DHHS's request, unless DHHS grants an extension to such timeframe.

5.5.6.2 DHHS shall review and approve the CAP within five (5) days of receipt.

5.5.6.3 The MCO shall implement the CAP in accordance with the timeframes specified in the CAP.

5.5.6.4 DHHS shall validate the implementation of the CAP and impose liquidated damages if it determines that the MCO failed to implement the CAP or a provision thereof as required.

5.5.7 Publication

5.5.7.1 DHHS may publish on its website, on a quarterly basis, a list of MCOs that had remedies imposed on them by DHHS during the prior quarter, the reasons for the imposition, and the type of remedy(ies) imposed.

5.5.7.2 MCOs that had their remedies reversed pursuant to the dispute resolution process prior to the posting shall not be listed.

5.5.8 Notice of Remedies

5.5.8.1 Prior to the imposition of remedies under this Agreement, except in the instance of required temporary management, DHHS shall issue written notice of remedies that shall include, as applicable, the following:

5.5.8.1.1 A citation to the law, regulation or Agreement provision that has been violated;

5.5.8.1.2 The remedies to be applied and the date the remedies shall be imposed;

5.5.8.1.3 The basis for DHHS's determination that the remedies shall be imposed;

5.5.8.1.4 The appeal rights of the MCO;

5.5.8.1.5 Whether a CAP is being requested;

5.5.8.1.6 The timeframe and procedure for the MCO to dispute DHHS's determination.

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5.5.8.1.6.1. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

5.5.8.1.7 If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the MCO's favor. [42 CFR 438.710(a)(1)-(2)]

5.6 State Audit Rights

5.6.1 DHHS, CMS, NHID, NH Department of Justice, the OIG, the Comptroller General and their designees shall have the right to audit the records and/or documents of the MCO or the MCO's Subcontractors during the term of this Agreement and for ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.6.2 HHS, the HHS Secretary, (or any person or organization designated by either), and DHHS, have the right to audit and inspect any books or records of the MCO or its Subcontractors pertaining to:

5.6.2.1 The ability of the MCO to bear the risk of financial losses.

5.6.2.2 Services performed or payable amounts under the Agreement. [Section 1903(m)(2)(A)(iv) of the Social Security Act]

5.6.3 In accordance with Exhibit O, no later than forty (40) business days after the end of the State Fiscal Year, the MCO shall provide DHHS a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

5.6.4 The report shall assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period.

5.6.5 DHHS shall share the report with internal and external auditors of the State and federal oversight agencies. The SSAE 16 Type 2 report shall include:

5.6.5.1 Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period;

5.6.5.2 Written assertion by the MCO's management about whether:

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- 5.6.5.2.1 The aforementioned description fairly presents the system in all material respects;
- 5.6.5.2.2 The controls were suitably designed to achieve the control objectives stated in that description; and
- 5.6.5.2.3 The controls operated effectively throughout the specified period to achieve those control objectives.
- 5.6.5.3 Report of the MCO's auditor, which:
- 5.6.5.3.1 Expresses an opinion on the matters covered in management's written assertion; and
- 5.6.5.3.2 Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.
- 5.6.6** The MCO shall notify DHHS if there are significant or material changes to the internal controls of the MCO.
- 5.6.6.1 If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.
- 5.6.7** The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.
- 5.6.8** DHHS may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing CAPs and review MCO compliance with requirements and standards as specified in this Agreement.
- 5.6.9** The MCO shall use reasonable efforts to respond to DHHS oral and written correspondence within one (1) business day of receipt.
- 5.6.10** The MCO shall file annual and interim financial statements in accordance with the standards set forth below.
- 5.6.11** Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners, annual audited financial statements that have been audited by an independent Certified Public Accountant. [42 CFR 438.3(m)]
- 5.6.11.1 Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.
- 5.6.12** The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by NHID.

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5.6.13 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners.

5.7 Dispute Resolution Process

5.7.1 Informal Dispute Process

5.7.1.1 In connection with any action taken or decision made by DHHS with respect to this Agreement, within thirty (30) calendar days following the action or decision, the MCO may protest such action or decision by the delivery of a written notice of protest to DHHS and by which the MCO may protest said action or decision and/or request an informal hearing with the NH Medicaid Director ("Medicaid Director").

5.7.1.2 The MCO shall provide DHHS with a written statement of the action being protested, an explanation of its legal basis for the protest, and its position on the action or decision.

5.7.1.3 The Director shall determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s).

5.7.1.3.1 The presentation and discussion of the disputed issue(s) shall be informal in nature.

5.7.1.4 The Director shall provide written notice of the time, format and location of the presentations.

5.7.1.5 At the conclusion of the presentations, the Director shall consider all evidence and shall render a written recommendation, subject to approval by the DHHS Commissioner, as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation.

5.7.1.6 The Director may appoint a designee to hear the matter and make a recommendation.

5.7.2 Hearing

5.7.2.1 In the event of a termination by DHHS, pursuant to 42 CFR Section 438.708, DHHS shall provide the MCO with notice and a pre-termination hearing in accordance with 42 CFR Section 438.710.

5.7.2.2 DHHS shall provide written notice of the decision from the hearing.

5.7.2.3 In the event of an affirming decision at the hearing, DHHS shall provide the effective date of the Agreement termination.

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5.7.2.4 In the event of an affirming decision at the hearing, DHHS shall give the Members of the MCO notice of the termination, and shall inform Members of their options for receiving Medicaid services following the effective date of termination. [42 CFR 438.710(b); 42 CFR 438.710(b)(2)(i) - (iii); 42 CFR 438.10]

5.7.3 No Waiver

5.7.3.1 The MCO's exercise of its rights under Section 5.5.1 (Reservation of Rights and Remedies) shall not limit, be deemed a waiver of, or otherwise impact the Parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of DHHS under RSA chapter 541-A, if applicable, or any applicable provisions of the NH Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

6 FINANCIAL MANAGEMENT

6.1 Financial Standards

6.1.1 In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with NHID regulations, to include RSA Chapter 404-F, and any other relevant laws and regulations.

6.1.2 The MCO shall maintain a risk-based capital ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

6.1.3 With the exception of payment of a claim for a medical product or service that was provided to a Member, and that is in accordance with a written agreement with the Provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

6.1.3.1 Risk-based capital ratio was less than two (2) for the most recent year filing, per RSA 404-F:14 (III); and

6.1.3.2 The MCO was not in compliance with the NHID solvency requirement.

6.1.4 The MCO shall notify DHHS within ten (10) calendar days when its agreement with an independent auditor or actuary has ended and seek approval of, and the name of the replacement auditor or actuary, if any from DHHS.

6.1.5 The MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

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6.1.6 The MCO shall submit data on the basis of which DHHS has the ability to determine that the MCO has made adequate provisions against the risk of insolvency.

6.1.7 The MCO shall inform DHHS and NHID staff by phone and by email within five (5) business days of when any key personnel learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the MCO to perform under this Agreement.

6.1.7.1 [Amendment #9:] The MCO shall prohibit clawback business arrangements whereby Pharmacy Benefit Managers (PBM) reimburse network pharmacies an initial drug reimbursement amount and dispensing fee, and subsequently the PBM receives remuneration for a portion of that fee that is unreported to the Department and its actuary.

6.2 Capitation Payments

6.2.1 Capitation payments made by DHHS and retained by the MCO shall be for Medicaid-eligible Members. [42 CFR 438.3(c)(2)]

6.2.1.1 [Amendment #5:] Capitation rates for the Term through June 30, 2020 are shown in Exhibit B (Capitation Rates).

6.2.1.2 For each of the subsequent years of the Agreement, actuarially sound per Member, per month capitated rates shall be paid as calculated and certified by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

6.2.1.3 Any rate adjustments shall be subject to the availability of State appropriations.

6.2.1.4 [Amendment #6:] Capitation rates shall be based on generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board. [42 CFR 457.10]

6.2.2 In the event the MCO incurs costs in the performance of this Agreement that exceed the capitation payments, the State and its agencies are not responsible for those costs and shall not provide additional payments to cover such costs.

6.2.3 The MCO shall report to DHHS within sixty (60) calendar days upon identifying any capitation or other payments in excess of amounts provided in this Agreement. [42 CFR 438.608(c)(3)]

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6.2.4 The MCO and DHHS agree that the capitation rates in Exhibit B (Capitation Rates) may be adjusted periodically to maintain actuarial soundness as determined by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

6.2.5 The MCO shall submit data on the basis of which the State certifies the actuarial soundness of capitation rates to an MCO, including base data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

6.2.6 When requested by DHHS, the MCO shall submit Encounter Data, financial data, and other data to DHHS to ensure actuarial soundness in development of the capitated rates, or any other actuarial analysis required by DHHS or State or federal law.

6.2.7 The MCO's CFO shall submit and concurrently certify to the best of his or her information, knowledge, and belief that all data and information described in 42 CFR 438.604(a), which DHHS uses to determine the capitated rates, is accurate. [42 CFR 438.606]

6.2.8 The MCO has responsibility for implementing systems and protocols to maximize the collection of TPL recoveries and subrogation activities. The capitation rates are calculated net of expected MCO recoveries.

6.2.9 DHHS shall make a monthly payment to the MCO for each Member enrolled in the MCO's plan as DHHS currently structures its capitation payments.

6.2.9.1 [Amendment #6:] Beginning contract year July 1, 2021, Specifically, the monthly capitation payments for all standard Medicaid Members shall be made retrospectively with a one month ~~three month~~ plus five (5) business day lag as soon as DHHS system modifications can be completed (for example, coverage for September 1, 2021 ~~July 1, 2019~~ shall be paid by the 5th business day in October ~~2021~~ 2019).

6.2.9.2 Capitation payments for all Granite Advantage Members shall be made before the end of each month of coverage.

6.2.10 Capitation rate cell is determined based on the Member characteristics as of the earliest date of Member plan enrollment span(s) within the month.

6.2.11 Capitation rate does not change during the month, regardless of Member changes (e.g., age), unless the Member's plan enrollment is terminated and the Member is re-enrolled resulting in multiple spans within the month.

6.2.12 The capitation rates shall be risk adjusted for purposes of this Agreement in an actuarially sound manner on a quarterly basis and certified by DHHS' actuary.

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6.2.12.1 [Amendment #10:] [Amendment #8:] [Amendment #6:] [Amendment #5:] The September 2019 to August 31, 2024 June-2024 2022-2023 capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.

~~[Amendment #2:] The September 2019 to June 2020 capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.~~

6.2.12.1.1 [Amendment #5:] [Amendment #2:] The risk adjustment process shall use the most recent version of the CDPS+Rx model to assign scored individuals to a demographic category and disease categories based on their medical claims and drug utilization during the study period. The methodology shall also incorporate a custom risk weight related to the cost of opioid addiction services. Scored individuals are those with at least six months of eligibility and claims experience in the base data. The methodology shall exclude diagnosis codes related to radiology and laboratory services to avoid including false positive diagnostic indicators for tests run on an individual. Additionally, each scored member with less than 12 months of experience in the base data period shall also be assigned a durational adjustment to compensate for missing diagnoses due to shorter enrollment durations, similar to a missing data adjustment.

6.2.12.1.2 [Amendment #2:] Each unscored member shall be assigned a demographic-only risk weight instead of receiving the average risk score for each MCO's scored members in the same rate cell. The risk adjustment methodology shall also incorporate a specific adjustment to address cost and acuity differences between the scored and unscored populations, which shall be documented by a thorough review of historical data for those populations based on generally accepted actuarial techniques.

6.2.12.1.3 [Amendment #2:] Members shall be assigned to MCOs and rate cells using the actual enrollment by MCO in each quarter to calculate risk scores in order to capture actual membership growth for each MCO.

6.2.12.1.4 [Amendment #5:] The capitation rates for the Non-Medically Frail population shall use an actuarially sound concurrent risk adjustment model to adjust the rates for each participating MCO until sufficient historical data is available to use a prospective risk adjustment model.

6.2.12.1.4.1. [Amendment #7:] Effective January 1, 2021, risk adjustment for the Non-Medically Frail

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population shall be performed on a prospective basis as described in this Section 6.2.12.1.

6.2.12.2 ~~[Amendment #9:]~~~~[Amendment #8:]~~ Intentionally left blank. For the period July 1, 2022 through June 30, 2023, capitation rates shall be subject to a retroactive acuity adjustment methodology to account for the change in enrollment during the public health emergency continuous enrollment unwind as authorized in writing by the Centers for Medicare and Medicaid Services Division of Managed Care Policy on May 11, 2022, and described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for this Amendment #8.

6.2.12.3 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024 capitation rates include a preliminary acuity adjustment based on DHHS's intended PHE unwind process and a detailed redetermination schedule to estimate the percentage of Members expected to leave the Medicaid program for each redetermination cohort as explained in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for this rating period Amendment. The adjustment will be updated for Amendment #11 capitation rates, as appropriate.

6.2.13 DHHS reserves the right to terminate or implement the use of a risk adjustment process for all or specific eligibility categories or services if it is determined to be necessary to do so to maintain actuarially sound rates or as a result of credibility considerations of a population's size as determined by DHHS's actuary.

6.2.14 Capitation adjustments are processed systematically each month by DHHS's MMIS.

6.2.15 DHHS shall make systematic adjustments based on factors that affect rate cell assignment or plan enrollment.

6.2.16 If a Member is deceased, DHHS shall recoup any and all capitation payments after the Member's date of death including any prorated share of a capitation payment intended to cover dates of services after the Member's date of death.

6.2.17 DHHS shall also make manual adjustments as needed, including manual adjustments for kick payments.

6.2.18 DHHS has sole discretion over the settlement process.

6.2.19 The MCO shall follow policies and procedures for the settlement process as developed by DHHS.

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6.2.20 Based on the provisions herein, DHHS shall not make any further retroactive adjustments other than those described herein or elsewhere in this agreement.

6.2.21 DHHS and the MCO agree that there is a nine (9) month limitation from the date of the capitation payment and is applicable only to retroactive capitation rate payments described herein, and shall in no way be construed to limit the effective date of enrollment in the MCO.

6.2.22 DHHS shall have the discretion to recoup payments retroactively up to twenty-four (24) months for Members whom DHHS later determines were not eligible for Medicaid during the enrollment month for which capitation payment was made.

6.2.23 For each live birth, DHHS shall make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.23.1 This payment is a global fee to cover all delivery care.

6.2.23.2 In the event of a multiple birth DHHS shall only make only one (1) maternity kick payment.

6.2.23.3 A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

6.2.24 For each live birth, DHHS shall make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.24.1 This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services.

6.2.24.2 For example, the newborn kick payment shall cover all services provided in July 2019 and August 2019 for a baby born any time in July 2019.

6.2.24.3 Enrolled babies shall be covered under the MCO capitated rates thereafter.

6.2.25 Different rates of newborn kick payments may be employed by DHHS, in its sole discretion, to increase actuarial soundness.

6.2.25.1 [Amendment #1:] For the period beginning September 1, 2019, two (2) newborn kick payments shall be employed, one (1) for newborns with NAS and one (1) for all other newborns. [Base Contract:] For the period beginning July 1, 2019, two (2) newborn kick payments shall be employed, one (1) for newborns with NAS and one (1) for all other newborns.

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6.2.25.2 Each type of payment is distinct and only one payment is made per newborn.

6.2.26 The MCO shall submit information on maternity and newborn events to DHHS, and shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

6.2.27 Payment for behavioral health rate cells shall be determined based on a Member's CMH Program or CMH Provider behavioral certification level as supplied in an interface to DHHS's MMIS by the MCO.

6.2.27.1 The CMH Program or CMH Provider behavioral certification level is based on a Member having had an encounter in the last six (6) months.

6.2.27.2 Changes in the certification level for a Member shall be reflected as of the first of each month and does not change during the month.

6.2.28 [Amendment #1:] Beginning September 1, 2019, after the completion of each Agreement year, an actuarially sound withhold percentage of each MCO's risk adjusted capitation payment net of directed payments to the MCO shall be calculated as having been withheld by DHHS. On the basis of the MCO's performance, as determined under DHHS's MCM Withhold and Incentive Guidance, unearned withhold in full or in part is subject to recoupment by DHHS to be used to finance an MCO incentive pool.
~~[Base Contract:] Beginning July 1, 2019, after the completion of each Agreement year, an actuarially sound withhold percentage of each MCO's risk adjusted capitation payment net of directed payments to the MCO shall be calculated as having been withheld by DHHS. On the basis of the MCO's performance, as determined under DHHS's MCM Withhold and Incentive Guidance, unearned withhold in full or in part is subject to recoupment by DHHS to be used to finance an MCO incentive pool.~~

6.2.29 Details of the MCM Withhold and Incentive Program are described in MCM Withhold and Incentive Program Guidance provided by DHHS as indicated in Section 5.4 (MCM Withhold and Incentive Payment Program).

6.2.30 DHHS shall inform the MCO of any required program revisions or additions in a timely manner.

6.2.31 DHHS may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

6.2.32 In the event an enrolled Medicaid Member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive the applicable capitation payment for that Member.

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6.2.33 The entity responsible for coverage of the Member at the time of admission as an inpatient (either DHHS or another MCO) shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

6.2.34 [Amendment #8:] Beginning July 1, 2022, DHHS shall only make a monthly capitation payment to the MCO for a Member aged 21–64 receiving inpatient treatment in an IMD, as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment, or as has been otherwise permitted by CMS through a waiver obtained from CMS. [42 CFR 438.6(e)]

6.2.35 Unless MCOs are exempted, through legislation or otherwise, from having to make payments to the NH Insurance Administrative Fund (Fund) pursuant to RSA 400-A:39, DHHS shall reimburse MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NHID.

6.2.36 [Amendment #5:] [Amendment #2:] For any Member with claims exceeding five hundred thousand dollars (\$500,000) or other attachment point described in this section for the fiscal year, after applying any third party insurance offset, DHHS shall reimburse fifty percent (50%) of the amount over the greater of five hundred thousand dollars (\$500,000) or the attachment point after all claims have been recalculated based on the DHHS fee schedule for the services and pro-rated for the contract year, as appropriate.

6.2.36.1 [Amendment #5:] The stop-loss attachment point of \$500,000 shall be indexed annually at a rate of 3.0% from its inception in SFY 2016 and rounded to the nearest \$1,000.

6.2.36.1.1 [Amendment #5:] For the period July 1, 2020 through June 30, 2021, the attachment point shall be \$580,000.

6.2.36.1.2 [Amendment #6:] For the period July 1, 2021 through June 30, 2022, the attachment point shall be \$597,000.

6.2.36.1.3 [Amendment #8:] For the period July 1, 2022 through June 30, 2023, the attachment point shall be \$615,000.

6.2.36.1.4 [Amendment #10:] For the period July 1, 2023 through August 31, 2024, the attachment point shall be \$740,000.

6.2.36.2 [Amendment #5] For a Member whose services may be projected to exceed the attachment point five hundred thousand

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dollars (\$500,000) in total MCO claims, the MCO shall advise DHHS in writing.

6.2.36.3 [Amendment #5:] Prior approval from the Medicaid Director is required for subsequent services provided to the Member.

6.2.36.4 [Amendment #5:] ~~[Amendment #2:] 6.2.36.1.1~~ Hospital inpatient and hospital outpatient services provided by Boston Children's Hospital are exempt from stop-loss protections referenced in this section.

6.2.37 [Amendment #2:] DHHS shall implement a budget neutral-risk pool for services provided at Boston Children's Hospital in order to better allocate funds based on MCO-specific spending for these services. Inpatient and outpatient facility services provided at Boston Children's Hospital qualify for risk pool calculation.

6.2.38 [Amendment #2:] Beginning September 1, 2019, the gene therapy medication Zolgensma used to treat spinal muscular atrophy (SMA) shall be carved-out of the at-risk services under the MCM benefit package. As such, costs for Zolgensma and other carved-out medications shall not be considered under the various risk mitigation provisions of the Agreement.

6.2.38.1 [Amendment #5:] For the contract period January 1, 2021 through June 30, 2021, the cost of the COVID-19 vaccine and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

6.2.38.2 [Amendment #10:] [Amendment #8:] [Amendment #6:] For the contract period July 1, 2023~~2024~~ through August 31, 2024~~the end of the federal Public Health Emergency Period June 30, 2022~~, the cost of the COVID-19 vaccines and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

6.2.38.3 [Amendment #8:] For the contract period July 1, 2022 through June 30, 2023, the cost of COVID vaccine counseling for children and youth ages 0 up to 21 years shall be under a non-risk payment arrangement as further described in guidance.

6.2.38.4 [Amendment #9:] Beginning January 1, 2023, high cost gene therapy and biological medications shall be under a non-risk payment arrangement and excluded under the various risk mitigation provisions of the Agreement as described in separate guidance.

6.2.39 [Amendment #4:] Beginning September 1, 2019, should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which

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CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. [Amendment #3:] Beginning September 1, 2019, should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must not implement that part after the effective date of the loss of program authority.

6.2.39.1 [Amendment #4:] The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. [Amendment #3:] The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law.

6.2.39.2 [Amendment #4:] If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work. [Amendment #3:] If the MCO received capitation payments that included costs specific to a program or activity no longer authorized by law prior to the effective date of the loss of authority for work that would be performed after that effective date, the state must adjust those capitation payments to ensure that previous reimbursement of costs specific to the program or activity no longer authorized is returned to the state and that costs specific to the program or activity no longer authorized are no longer paid by the state after the effective date of the loss of program authority.

6.2.39.3 [Amendment #4:] If the state paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. [Amendment #3:] Capitation payments received prior to the effective date of loss of program authority that included costs for work specific to the program or activity that is no longer authorized, but that was performed prior to that effective date, may be retained by the managed care plan and need not be returned to the state.

6.2.39.4 [Amendment #4:] However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

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6.2.40 [Amendment #4:] To account for attributable costs related to the HB 4 January 2021 provider rate increase and unknown development of COVID-19 costs, a January 2021 rate refresh shall be conducted.

6.2.41 [Amendment #10:] [Amendment #8:] For the July 1, 20232022 through August 31, 2024June 30, 2023 rating period, DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG codes 880-887, except as described in Section 6.2.41.3 below.

[Amendment #7:] For the July 1, 2021 through June 30, 2022 rating period, DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG code 880-887, and the State Plan rate for Hampstead Hospital.

6.2.41.1 [Amendment #6:] The kick payment shall be specific to the corresponding Peer Groups established by DHHS. Separate kick payments exist for Peer Group 01 and 07, Peer Group 02, Peer Group 06, and Peer Group 09.

6.2.41.2 [Amendment #6:] Psychiatric admissions for dually eligible Members are not subject to the kick payment and shall be paid out of the capitation rates.

6.2.41.3 [Amendment #8:][Amendment #6:] Psychiatric admissions for adult Members at New Hampshire Hospital and Hampstead Hospital are not subject to the kick payment and shall be paid out of the MCO's capitation rates.

6.2.42 [Amendment #7:] Intentionally left blank [Amendment #6:] Effective July 1, 2021, DHHS shall initially pay capitation rates based on the December 2021 Public Health Emergency (PHE) scenario of the PHE ending December 2021 or later.

6.2.42.1 [Amendment #7:] Intentionally left blank [Amendment #6:] In the event the PHE ends prior to October 1, 2021, DHHS shall retroactively pay capitation rates developed under the September 2021 scenario as described in the actuarial rate report for the period July 1, 2021 through June 30, 2022.

6.3 [Amendment #6:] Medical Loss Ratio Reporting and Settlement

6.3.1 Minimum Medical Loss Ratio Performance and Rebate Requirements

6.3.1.1 The MCO shall meet a minimum MLR of eighty-five percent (85%) or higher.

6.3.1.2 In the event the MCO's MLR for any single reporting year is below the minimum of the eighty-five percent (85%) requirement, the MCO shall provide to DHHS a rebate, no later than sixty (60)

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calendar days following DHHS notification, that amounts to the difference between the total amount of Capitation Payments received by the MCO from DHHS multiplied by the required MLR of eighty-five percent (85%) and the MCO's actual MLR. [42 CFR 438.8(j); 42 CFR 438.8(c)]

6.3.1.3 If the MCO fails to pay any rebate owed to DHHS in accordance with the time periods set forth by DHHS, in addition to providing the required rebate to DHHS, the MCO shall pay DHHS interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher, on the total amount of the rebate.

6.3.2 Calculation of the Medical Loss Ratio

6.3.2.1 The MCO shall calculate and report to DHHS the MLR for each MLR reporting year, in accordance with 42 CFR 438.8 and the standards described within this Agreement. [42 CFR 438.8(a)]

6.3.2.2 The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)). [42 CFR 438.8 (d)-(f)].

6.3.2.3 Each MCO expense shall be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense shall be pro-rated between the two types of expenses.

6.3.2.3.1 Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on a pro rata basis. [42 CFR 438.8(g)(1)(i)-(ii)]

6.3.2.4 Expense allocation shall be based on a generally accepted accounting method that is extended to yield the most accurate results.

6.3.2.4.1 Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

6.3.2.4.2 Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to other entities. [42 CFR 438.8(g)(2)(i)-(iii)]

6.3.2.5 The MCO may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

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6.3.2.5.1 The credibility adjustment, if included, shall be added to the reported MLR calculation prior to calculating any remittances.

6.3.2.5.2 The MCO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

6.3.2.5.3 If the MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. [42 CFR 438.8(h)(1)-(3)]

6.3.3 Medical Loss Ratio Reporting

6.3.3.1 The MCO shall submit MLR summary reports quarterly to DHHS in accordance with Exhibit O [42 CFR 438.8(k)(2); 42 CFR 438.8(k)(1)].

6.3.3.2 The MLR summary reports shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year, including:

6.3.3.2.1 Total incurred claims;

6.3.3.2.2 Expenditures on quality improvement activities;

6.3.3.2.3 Expenditures related to activities compliant with the program integrity requirements;

6.3.3.2.4 Non-claims costs;

6.3.3.2.5 Premium revenue;

6.3.3.2.6 Taxes;

6.3.3.2.7 Licensing fees;

6.3.3.2.8 Regulatory fees;

6.3.3.2.9 Methodology(ies) for allocation of expenditures;

6.3.3.2.10 Any credibility adjustment applied;

6.3.3.2.11 The calculated MLR;

6.3.3.2.12 Any remittance owed to the State, if applicable;

6.3.3.2.13 A comparison of the information reported with the audited financial report;

6.3.3.2.14 A description of the aggregate method used to calculate total incurred claims; and

6.3.3.2.15 The number of Member months. [42 CFR 438.8(k)(1)(i)-(xiii); 42 CFR 438.608(a)(1)-(5); 42 CFR 438.608(a)(7)-(8); 42 CFR 438.608(b); 42 CFR 438.8(i)]

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6.3.3.3 The MCO shall attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to DHHS. [42 CFR 438.8(n); 42 CFR 438.8(k)]

6.3.3.4 Such summary reports shall be based on a template developed and provided by DHHS within sixty (60) calendar days of the Program Start Date. [42 CFR 438.8(a)]

6.3.3.5 The MCO shall in its MLR summary reports aggregate data for all Medicaid eligibility groups covered under this Agreement unless otherwise required by DHHS. [42 CFR 438.8(i)]

6.3.3.6 The MCO shall require any Subcontractor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCO within one hundred and eighty (180) calendar days or the end of the MLR reporting year or within thirty (30) calendar days of a request by the MCO, whichever comes sooner, regardless of current contract limitations, to calculate and validate the accuracy of MLR reporting. [42 CFR 438.8(k)(3)]

6.3.3.7 In any instance in which DHHS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to DHHS, the MCO shall:

6.3.3.7.1 Re-calculate the MLR for all MLR reporting years affected by the change; and

6.3.3.7.2 Submit a new MLR report meeting the applicable requirements. [42 CFR 438.8(m); 42 CFR 438.8(k)]

6.3.3.8 The MCO and its Subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

6.3.4 [Amendment #6:] Minimum and Maximum Medical Loss Ratios

6.3.4.1 [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] For the period July 1, ~~2023~~~~2022~~~~2021~~ through August 31, ~~2024~~~~June 30, 2022-2023~~, the target MLR for at-risk services is ~~90.98%~~90.8% for Standard Medicaid and ~~89.9%~~90.21% for GAHCP based on the SFY 2023 projected enrollment distribution for the rating period. Please note, each program's target MLR may change in future rate amendments as a result of changes to underlying assumptions, such as enrollment projections, emerging utilization experience, and the retroactive acuity adjustments, if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period. The minimum MLR is set on a program wide basis for each major

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~~population, such that the maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs below: shall limit the MCO's gain to four percent (4%). The maximum MLR shall limit the MCO's loss to two three and one half percent (3.5 2.5%) over the target MLR.~~

6.3.4.1.1 [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] The minimum MLR is set on a program-wide basis for each major population, such that the maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). The minimum MLR shall be ~~88.2~~ 88.343% for the Standard Medicaid population and ~~87.4~~ 87.476% for the GAHCP population.

6.3.4.1.2 [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCOs will have a maximum loss of 2.0%. Based on the target MLRs, the maximum MLR shall be ~~94.2~~ 94.343% ~~shall be 94.2~~ 94.3% for the Standard Medicaid population and ~~93.4~~ 93.476% for the GAHCP population.

6.3.4.1.2.1. [Amendment #9] [Amendment #8:] The final maximum and minimum MLRs for Standard Medicaid and GAHCP shall be updated for the final retroactive acuity factor and any other changes implemented in the ~~expected January 2023~~ contract amendment, as applicable.

6.3.4.1.3 [Amendment #6:] The settlement shall be done separately for the Standard Medicaid and GAHCP populations.

6.3.4.1.4 [Amendment #9:] [Amendment #8:] [Amendment #6:] Other MCM program risk mitigation provisions shall apply prior to the minimum and maximum MLR calculation ~~risk corridor~~ (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, ~~and~~ prospective risk adjustment, and retrospective acuity adjustment), if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

6.3.4.1.5 [Amendment #8:] [Amendment #6:] The numerator of the MCO's actual MLR shall include all payments made to providers, such as fee-for-service payments, sub-capitation payments, incentive payments, and settlement payments. The numerator of

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each MCO's actual MLR shall not include costs related to quality improvement expenses or fraud, waste and abuse prevention.

6.3.4.1.6 [Amendment #6:] Payments and revenue related to directed payments and premium taxes shall be excluded from the numerator and denominator of the MCO's actual MLR.

6.3.4.1.7 [Amendment #6:] Any incentive payments made to higher-performing MCOs as part of the Withhold Program shall not impact the minimum or maximum MLR provision of the contract.

6.3.4.1.8 [Amendment #6:] The timing of the minimum and maximum MLR settlement shall occur after the contract year is closed and substantial paid claims runout is available.

6.3.4.1.8.1. [Amendment #8:] Payments related to the Withhold and Incentive Program shall be excluded from the minimum and maximum MLR settlement.

6.4 Financial Responsibility for Dual-Eligible Members

6.4.1 [Amendment #7:] For Medicare Part A crossover claims and Medicare Part B crossover claims billed on the UB-04, the MCO shall pay the patient responsibility amount (deductible and coinsurance) for covered services. For the period July 1, 2021 through June 30, 2022, the minimum MLR shall limit the MCO's gain to four percent (4%). The maximum MLR shall limit the MCO's loss to three and one-half percent (3 1/2%) over the target MLR.

6.4.2 For Part B crossover claims billed on the CMS-1500, the MCO shall pay the lesser of:

6.4.2.1 [Amendment #7:] The patient responsibility amount (deductible and coinsurance) for covered services, or

6.4.2.2 The difference between the amount paid by the primary payer and the Medicaid allowed amount.

6.4.3 For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO shall make no payment.

6.5 Medical Cost Accruals

6.5.1 The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims, services rendered for which claims have not been received.

6.6 Audits

6.6.1 The MCO shall permit DHHS or its designee(s) and/or the NHID to inspect and audit any of the financial records of the MCO and its Subcontractors.

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6.6.2 There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. [42 CFR 438.6(g), SMM 2087.7; 42 CFR 434.6(a)(5)]

6.6.3 The MCO shall file annual and interim financial statements in accordance with the standards set forth in this Section 6 (Financial Management) of this Agreement.

6.6.3.1 This Section shall supersede any conflicting requirements in Exhibit C (Special Provisions) of this Agreement.

6.6.4 Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the NAIC, annual audited financial statements that have been audited by an independent Certified Public Accountant.

6.6.4.1 Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

6.6.5 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the NHID.

6.6.6 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

6.7 Member Liability

6.7.1 The MCO shall not hold MCM Members liable for:

6.7.1.1 The MCO's debts, in the event of the MCO's insolvency;

6.7.1.2 The Covered Services provided to the Member, for which the State does not pay the MCO;

6.7.1.3 The Covered Services provided to the Member, for which the State, or the MCO does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement; or

6.7.1.4 Payments for Covered Services furnished under an agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the MCO provided those services directly. [42 CFR 438.106(a)-(c);

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section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230]

6.7.2 The MCO shall provide assurances satisfactory to DHHS that its provision against the risk of insolvency is adequate to ensure that Medicaid Members shall not be liable for the MCO's debt if the MCO becomes insolvent. [42 CFR 438.116(a)]

6.7.3 Subcontractors and Referral Providers may not bill Members any amount greater than would be owed if the entity provided the services directly [Section 1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; 42 CFR 438.204(a); SMDL 12/30/97].

6.7.4 The MCO shall cover services to Members for the period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency. [SMM 2086.6B]

6.7.5 The MCO shall meet DHHS's solvency standards for private health maintenance organizations, or be licensed or certified by DHHS as a risk-bearing entity. [Section 1903(m)(1) of the Social Security Act; 42 CFR 438.116(b)]

6.8 Denial of Payment

6.8.1 Payments provided for under the Agreement shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS.

6.8.2 CMS may deny payment to the State for new Members if its determination is not timely contested by the MCO. [42 CFR 438.726(b); 42 CFR 438.730(e)(1)(ii)]

6.9 Federal Matching Funds

6.9.1 Federal matching funds are not available for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services. [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and Section 1903(i)(2) of the SSA; SMDL 12/30/97]

6.9.2 Payments made to such Providers are subject to recoupment from the MCO by DHHS.

6.10 Health Insurance Providers Fee

6.10.1 The Affordable Care Act imposed an annual fee on health insurance Providers beginning in 2014 ("Annual Fee").

6.10.1.1 [Amendment #6:] The Further Consolidated Appropriations Act, 2020, repealed the annual fee on health insurance Providers for calendar years beginning after December 31, 2020; therefore, calendar year 2020 shall be the last fee year.

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6.10.2 The MCO is responsible for a percentage of the Annual Fee for all health insurance Providers as determined by the ratio of MCO's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

6.10.3 To the extent such fees exist and DHHS is legally obligated to pay such fees under Federal law:

6.10.3.1 The State shall reimburse the MCO for the amount of the Annual Fee specifically allocable to the premiums paid during the Term of this Agreement for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee").

6.10.3.2 The MCO's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount the MCO or the MCO's parent receives from the United States Internal Revenue Service.

6.10.3.3 The State shall provide reimbursement no later than one hundred and twenty (120) business days following its review and acceptance of the MCO's Adjusted Fee.

6.10.3.4 To claim reimbursement for the MCO's Adjusted Fee, the MCO shall submit a certified copy of its full Annual Fee assessment within sixty (60) business days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums, under this Agreement.

6.10.3.5 The MCO shall also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums, and any other data deemed necessary by the State to validate the reimbursement amount.

6.10.3.6 These materials shall be submitted under the signatures of either its Financial Officer or CEO/Executive Director, certifying the accuracy, truthfulness and completeness of the data provided.

6.11 Third Party Liability

6.11.1 NH Medicaid shall be the payor of last resort for all Covered Services in accordance with federal regulations.

6.11.2 The MCO shall develop and implement policies and procedures to meet its obligations regarding TPL. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.3 DHHS and the MCO shall cooperate in implementing cost avoidance and cost recovery activities.

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6.11.4 The MCO shall be responsible for making every reasonable effort to determine the liable third party to pay for services rendered and cost avoid and/or recover any such liabilities from the third party.

6.11.5 DHHS shall conduct two (2) TPL policy and procedure audits of the MCO and its Subcontractors per Agreement year.

6.11.5.1 Noncompliance with CAPs issued due to deficiencies may result in liquidated damages as outlined in Exhibit N.

6.11.6 The MCO shall have one (1) dedicated contact person for DHHS for TPL.

6.11.7 DHHS and/or its actuary shall identify a market-expected median TPL percentage amount and deduct an appropriate amount from the gross medical costs included in the DHHS Capitation Payment rate setting process.

6.11.8 All cost recovery amounts, even those greater than identified in the rate cells, shall be retained by the MCO.

6.11.9 The MCO and its Subcontractors shall comply with all regulations and State laws related to TPL, including but not limited to:

6.11.9.1 42 CFR 433.138;

6.11.9.2 42 CFR 433.139; and

6.11.9.3 RSA 167:14-a.

6.11.10 Cost Avoidance

6.11.10.1 The MCO and its Subcontractors performing claims processing duties shall be responsible for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources, including but not limited to Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1396a(a)(25) plans and workers compensation.

6.11.10.2 The MCO shall establish claims edits and deny payment of claims when active Medicare or active private insurance exists at the time the claim is adjudicated and the claim does not reflect payment from the other payer.

6.11.10.3 The MCO shall deny payment on a claim that has been denied by Medicare or private insurance when the reason for denial is the Provider or Member's failure to follow prescribed procedures including, but not limited to, failure to obtain Prior Authorization or timely claim filing.

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6.11.10.4 The MCO shall establish claim edits to ensure claims with Medicare or private insurance denials are properly denied by the MCO.

6.11.10.5 The MCO shall make its own independent decisions about approving claims for payment that have been denied by the private insurance or Medicare if either:

6.11.10.5.1 The primary payor does not cover the services and the MCO does; or

6.11.10.5.2 The service was denied as not Medically Necessary and the Provider followed the dispute resolution and/or Appeal Process of the private insurance or Medicare and the denial was upheld.

6.11.10.6 If a claim is denied by the MCO based on active Medicare or active private insurance, the MCO shall provide the Medicare or private insurance information to the Provider.

6.11.10.7 To ensure the MCO is cost avoiding, the MCO shall implement a file transfer protocol between DHHS MMIS and the MCO's MCIS to receive and send Medicare and private insurance information and other information as required pursuant to 42 CFR 433.138.

6.11.10.8 The MCO shall implement a nightly file transfer protocol with its Subcontractors to ensure Medicare, private health insurance, ERISA, 29 U.S.C. 1396a(a)(25) plans, and workers compensation policy information is updated and utilized to ensure claims are properly denied for Medicare or private insurance.

6.11.10.9 The MCO shall establish, and shall ensure its Subcontractors utilize, monthly electronic data matches with private insurance companies (Medical and pharmacy) that sell insurance in the State to obtain current and accurate private insurance information for their Members. This provision may be satisfied by a contract with a third-party vendor to the MCO or its Subcontractors. Notwithstanding the above, the MCO remains solely responsible for meeting the requirement.

6.11.10.10 Upon audit, the MCO shall demonstrate with written documentation that good faith efforts were made to establish data matching agreements with insurers selling in the State who have refused to participate in data matching agreements with the MCO.

6.11.10.11 The MCO shall maintain the following private insurance data within their system for all insurance policies that a Member may have and include for each policy:

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- 6.11.10.11.1 Member's first and last name;
- 6.11.10.11.2 Member's policy number;
- 6.11.10.11.3 Member's group number, if available;
- 6.11.10.11.4 Policyholder's first and last name;
- 6.11.10.11.5 Policy coverage type to include at a minimum:
 - 6.11.10.11.5.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below).
 - 6.11.10.11.5.2. Hospital coverage,
 - 6.11.10.11.5.3. Pharmacy coverage,
 - 6.11.10.11.5.4. Dental coverage, and
 - 6.11.10.11.5.5. Vision Coverage;
- 6.11.10.11.6 Begin date of insurance; and
- 6.11.10.11.7 End date of insurance (when terminated).
- 6.11.10.12** The MCO shall submit any new, changed, or terminated private insurance data to DHHS through file transfer on a weekly basis.
- 6.11.10.13** The MCO shall not cost avoid claims for preventive pediatric services (including EPSDT), that is covered under the Medicaid State Plan per 42.CFR 433.139(b)(3).
- 6.11.10.14** The MCO shall pay all preventive pediatric services and collect reimbursement from private insurance after the claim adjudicates.
- 6.11.10.15** The MCO shall pay the Provider for the Member's private insurance cost sharing (Copays and deductibles) up to the MCO Provider contract allowable.
- 6.11.10.16** On a quarterly basis, the MCO shall submit a cost avoidance summary, as described in Exhibit O.
- 6.11.10.17** This report shall reflect the number of claims and dollar amount avoided by private insurance and Medicare for all types of coverage as follows:
 - 6.11.10.17.1 Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);
 - 6.11.10.17.2 Hospital coverage;

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- 6.11.10.17.3 Pharmacy coverage;
- 6.11.10.17.4 Dental coverage; and
- 6.11.10.17.5 Vision coverage.

6.11.11 Post Payment Recovery

6.11.11.1 Definitions

6.11.11.1.1 Pay and Chase means recovery of claims paid in which Medicare or private insurance was not known at the time the claim was adjudicated.

6.11.11.1.2 Subrogation means personal injury, liability insurance, automobile/home insurance, or accident indemnity insurance where a third party may be liable.

6.11.11.2 Pay and Chase Private Insurance

6.11.11.2.1 If private insurance exists for services provided and paid by the MCO, but was not known by the MCO at time the claim was adjudicated, then the MCO shall pursue recovery of funds expended from the private insurance company.

6.11.11.2.2 The MCO shall submit quarterly recovery reports, in accordance with Exhibit O.

6.11.11.2.3 These reports shall reflect detail and summary information of the MCO's collection efforts and recovery from Medicare and private insurance for all types of coverage as follows:

6.11.11.2.3.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or another other health coverage not listed below);

6.11.11.2.3.2. Hospital coverage;

6.11.11.2.3.3. Pharmacy coverage;

6.11.11.2.3.4. Dental coverage; and

6.11.11.2.3.5. Vision Coverage.

6.11.11.2.4 [Amendment #5:] The MCO shall have eight (8) months from the original paid date to initiate recovery of recover funds from private insurance.

6.11.11.2.4.1. [Amendment #5:] ~~If funds have not been recovered by that date, the claim is not on the Exhibit O TPLCOB.02 or TPLCOB.03 report for recovery within 8 months of the paid date,~~ DHHS has the sole and

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exclusive right to pursue, collect, and retain funds from private insurance.

6.11.11.2.4.2. [Amendment #5:] If a recovery is closed on the Exhibit O TPLCOB.02 or TPLCOB.03 report for any reason, DHHS has the right to initiate collections from private insurance, after the MCO closure, and retain any funds recovered.

6.11.11.2.5 The MCO shall treat funds recovered from private insurance as offsets to the claims payments by posting within the claim system.

6.11.11.2.5.1. The MCO shall post all payments to claim level detail by Member.

6.11.11.2.5.2. Any Overpayment by private insurance can be applied to other claims not paid or covered by private insurance for the same Member.

6.11.11.2.5.3. Amounts beyond a Member's outstanding claims shall be returned to the Member.

6.11.11.2.6 The MCO and its Subcontractors shall not deny or delay approval of otherwise covered treatment or services based on TPL considerations, nor bill or pursue collection from a Member for services.

6.11.11.2.7 The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of TPL is established at the time the claim is adjudicated. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.11.3 Subrogation Recoveries

6.11.11.3.1 The MCO shall be responsible for pursuing recoveries of claims paid when there is an accident or trauma in which there is a third party liable, such as automobile insurance, malpractice, lawsuit, including class action lawsuits.

6.11.11.3.2 The MCO shall act upon any information from insurance carriers or attorneys regarding potential subrogation cases. The MCO shall be required to seek Subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines.

6.11.11.3.3 The MCO shall establish detailed policies and procedures for determining, processing, and recovering funds based on accident and trauma Subrogation cases.

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6.11.11.3.4 The MCO shall submit its policies and procedures, including those related to their case tracking system as described in Section 6.11.11.3.6, to DHHS for approval during the readiness review process. The MCO shall have in its policies and procedures, at a minimum, the following:

6.11.11.3.4.1. The MCO shall establish a paid claims review process based on diagnosis and trauma codes to identify claims that may constitute an accident or trauma in which there may be a liable third party.

6.11.11.3.4.2. The claims required to be identified, at a minimum, should include ICD-10 diagnosis codes related to accident or injury and claims with an accident trauma indicator of "Y".

6.11.11.3.4.3. The MCO shall present a list of ICD-10 diagnostic codes to DHHS for approval in identifying claims for review.

6.11.11.3.4.4. DHHS reserves the right to require specific codes be reviewed by MCO.

6.11.11.3.4.5. The MCO shall establish a monthly process to request additional information from Members to determine if there is a liable third party for any accident or trauma related claims by establishing a questionnaire to be sent to Members.

6.11.11.3.4.6. The MCO shall submit a report of questionnaires generated and sent as described in Exhibit O.

6.11.11.3.4.7. The MCO shall establish timeframes and claim logic for determining when additional letters to Members should be sent relating to specific accident diagnosis codes and indicators.

6.11.11.3.4.8. The MCO shall respond to accident referrals and lien request within twenty-one (21) calendar days of the notice per RSA 167:14-a.

6.11.11.3.5 The MCO shall establish a case tracking system to monitor and manage Subrogation cases.

6.11.11.3.6 This system shall allow for reporting of case status at the request of DHHS, OIG, CMS, and any of their designees. The tracking system shall, at a minimum, maintain the following record:

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- 6.11.11.3.6.1. Date inquiry letter sent to Member, if applicable;
- 6.11.11.3.6.2. Date inquiry letter received back from Member, if applicable;
- 6.11.11.3.6.3. Date of contact with insurance company, attorney, or Member informing the MCO of an accident;
- 6.11.11.3.6.4. Date case is established;
- 6.11.11.3.6.5. Date of incident;
- 6.11.11.3.6.6. Reason for incident;
- 6.11.11.3.6.7. Claims associated with incident;
- 6.11.11.3.6.8. All correspondence and dates;
- 6.11.11.3.6.9. Case comments by date;
- 6.11.11.3.6.10. Lien amount and date updated;
- 6.11.11.3.6.11. Settlement amount;
- 6.11.11.3.6.12. Date settlement funds received; and
- 6.11.11.3.6.13. Date case closed.

6.11.11.3.7 The MCO shall submit Subrogation reports in accordance with Exhibit O. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.11.3.8 DHHS shall inform the MCO of any claims related to an MCO Subrogation cases.

6.11.11.3.9 The MCO shall submit to DHHS any and all information regarding the case if DHHS also has a Subrogation lien.

6.11.11.3.10 [Amendment #5:] The MCO shall coordinate with DHHS on any dual Subrogation settlement recoveries identified in writing by DHHS. DHHS claims shall be paid first in any dual Subrogation settlement.

6.11.11.3.10.1. [Amendment #5:] The MCO shall pay DHHS claims first in the event of any settlement less than the combined total MCO and DHHS lien amount.

6.11.11.3.10.2. [Amendment #5:] The MCO shall be liable for repayment to DHHS for the total DHHS lien amount in situations when DHHS informed the MCO of the State's lien in advance of the settlement, regardless of whether the DHHS lien amount exceeds the total

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settlement amount recovered when the MCO settles a subrogation case and accepts a settlement amount without written authorization from DHHS.

6.11.11.3.11 The MCO shall submit to DHHS for approval any Subrogation proposed settlement agreement that is less than eighty percent (80%) of the total lien in which the MCO intends to accept prior to acceptance of the settlement.

6.11.11.3.12 DHHS shall have twenty (20) business days to review the case once the MCO provides all relevant information as determined by DHHS to approve the settlement from date received from the MCO.

6.11.11.3.13 If DHHS does not respond within twenty (20) business days, the MCO may proceed with settlement.

6.11.11.3.14 If DHHS does not approve of the settlement agreement, then DHHS may work with the MCO and other parties on the settlement.

6.11.11.3.15 DHHS shall have exclusive rights to pursue subrogations in which the MCO does not have an active subrogation case within one hundred and eighty (180) calendar days of receiving a referral, of sending the first questionnaire as referenced in 6.11.11.3.4.5 of this Section, or of claim paid date if no action was taken since claims paid date.

6.11.11.3.16 In the event that there are outstanding Subrogation settlements at the time of Agreement termination, the MCO shall assign DHHS all rights to such cases to complete and collect on those Subrogation settlements.

6.11.11.3.17 DHHS shall retain all recoveries after Agreement termination.

6.11.11.3.18 The MCO shall treat funds recovered due to Subrogation, if not processed as part of claims, outside of the claims processing system as offsets to medical expenses for the purpose of reporting.

6.11.11.4 Medicare

6.11.11.4.1 The MCO shall be responsible for coordinating benefits for dually eligible Members, if applicable.

6.11.11.4.2 The MCO shall enter into a Coordination of Benefits Agreement (COBA) for NH with Medicare and participate in the automated crossover process. [42 CFR 438.3(t)]

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6.11.11.4.3 A newly contracted MCO shall have ninety (90) calendar days from the start of this Agreement to establish and start file transfers with COBA.

6.11.11.4.4 The MCO and its Subcontractors shall establish claims edits to ensure that:

6.11.11.4.4.1. Claims covered by Medicare part D are denied when a Member has an active Medicare part A or Medicare part B;

6.11.11.4.4.2. Claims covered by Medicare part B are denied when a Member has an active Medicare part B; and

6.11.11.4.4.3. The MCO treats Members with Medicare part C as if they had Medicare part A and Medicare part B and shall establish claims edits and deny part D for those part C Members.

6.11.11.4.5 If Medicare was not known or active at the time a claim was adjudicated but was determined active or retroactive at a later date, the MCO shall recoup funds from the Provider and require the Provider to pursue Medicare payment for all claim types except Medicare part D.

6.11.11.4.5.1. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.11.11.4.6 If Medicare was not known or active at the time a claim was submitted by a Provider to the MCO, but was determined active or retroactive subsequent to the MCO's payment of the claim, the MCO shall recoup funds from the Provider and the Provider may pursue Medicare payment, except for Medicare Part D, for all claim types, provided the claims remain within the timely filing requirements.

6.11.11.4.6.1. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.11.11.4.7 The MCO shall contact DHHS if Members' claims were denied due to the lack of active Medicare part D or Medicare part B.

6.11.11.4.8 The MCO shall pay applicable Medicare coinsurance and deductible amounts as outlined in Section 6.4 (Financial Responsibility for Dual-Eligible Members). These payments are included in the calculated Capitation Payment.

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6.11.11.4.9 The MCO shall pay any wrap around services not covered by Medicare that are services under the Medicaid State Plan Amendment and this Agreement.

6.11.11.5 Estate Recoveries

6.11.11.5.1 DHHS shall be solely responsible for estate recovery activities and shall retain all funds recovered through these activities.

6.12 [Amendment #3:] Risk Corridors

6.12.1 [Amendment #3:] Subject to CMS approval, DHHS shall implement a risk corridor as described in Table 1, for the September 2019 to June 2020 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

**[Amendment #3:]
 Table 1
 New Hampshire Department of Health and Human Services
 Medicaid Care Management Program
 [Amendment #4:] Proposed September 2019 to June 2020
 MCM Program Risk Corridor Parameters**

<u>MLR Claims Corridor</u>	<u>MCO Share of Gain / Loss in Corridor</u>	<u>DHHS Share of Gain / Loss in Corridor</u>
Less than Target MLR - 3.5%	0%	100%
Target MLR - 3.5% to Target MLR - 2.0%	75%	25%
Target MLR - 2.0% to Target MLR + 1.5%	100%	0%
Target MLR + 1.5% to Target MLR + 3.5%	75%	25%
Greater than Target MLR + 3.5%	0%	100%

6.12.1.1 [Amendment #3:] The MCO capitation rates reflect a target medical loss ratio (MLR) which measures the projected medical service costs as a percentage of the total MCO capitation rates. The risk corridor would limit MCO gains and losses if the actual MLR is different than the target MLR.

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6.12.1.2 [Amendment #3:] The MCM program target MLR for at-risk services is 89.6% for Standard Medicaid and 88.7% for GAHCP based on the September 2019 to June 2020 projected enrollment distribution. Target MLRs will be calculated separately for each MCO based on their actual enrollment mix by rate cell.

6.12.1.3 [Amendment #3:] Table 1 summarizes the share of gains and losses relative to the target MLR for each party. . .

6.12.1.4 [Amendment #3:] The settlement will be done separately for the Standard Medicaid and GAHCP populations.

6.12.1.5 [Amendment #3:] Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment).

6.12.1.6 [Amendment #3:] The numerator of each MCO's actual MLR will include all payments made to providers, such as fee-for-service payments, subcapitation payments, incentive payments, and settlement payments.

6.12.1.7 [Amendment #3:] Payments and revenue related to directed payments and premium taxes will be excluded from the numerator and denominator of each MCO's actual MLR, which is consistent with the treatment of directed payments and premium taxes in federal MLR calculations.

6.12.1.8 [Amendment #3:] The 85% minimum MLR provision in the MCM contract will apply after the risk corridor settlement calculation. The 85% minimum MLR provision is adjudicated using federal MLR reporting rules, which produce a different MLR than the MLR calculated for risk corridor settlement purposes.

6.12.1.9 [Amendment #3:] The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

6.12.2 [Amendment #4:] Subject to CMS approval, DHHS shall implement a risk corridor as described in Table 1, for the July 2020 to June 2021 (SFY 2021) contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

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Table 1 New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2021 MCM Program Risk Corridor Parameters		
MLR Claims Corridor	MCO Share of Gain / Loss in Corridor	DHHS Share of Gain / Loss in Corridor
Less than Target MLR - 3.5%	0%	100%
Target MLR - 3.5% to Target MLR - 1.5%	50%	50%
Target MLR - 1.5% to Target MLR + 1.5%	100%	0%
Target MLR + 1.5% to Target MLR + 3.5%	50%	50%
Greater than Target MLR + 3.5%	0%	100%

6.12.2.1 [Amendment #4:] The MCO capitation rates reflect a target medical loss ratio (MLR) which measures the projected medical service costs as a percentage of the total MCO capitation rates. The risk corridor would limit MCO gains and losses if the actual MLR is different than the target MLR.

6.12.2.2 [Amendment #4:] The MCM program target MLR for at-risk services is 89.5% for Standard Medicaid and 88.6% for GAHCP based on the July 2020 to June 2021 projected enrollment distribution. Target MLRs will be calculated separately for each MCO based on their actual enrollment mix by rate cell.

6.12.2.3 [Amendment #4:] Table 1 summarizes the share of gains and losses relative to the target MLR for each party.

6.12.2.4 [Amendment #4:] The settlement will be done separately for the Standard Medicaid and GAHCP populations.

6.12.2.5 [Amendment #5:] Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment). [Amendment #4:] ~~Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment).~~

6.12.2.6 [Amendment #4:] The numerator of each MCO's actual MLR will include all payments made to providers, such as fee-for-service payments, subcapitation payments, incentive payments, and settlement payments.

6.12.2.7 [Amendment #4:] Payments and revenue related to directed payments and premium taxes will be excluded from the numerator and denominator of each MCO's actual MLR, which is

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consistent with the treatment of directed payments and premium taxes in federal MLR calculations.

6.12.2.8 [Amendment #4:] The 85% minimum MLR provision in the MCM contract will apply after the risk corridor settlement calculation. The 85% minimum MLR provision is adjudicated using federal MLR reporting rules, which produce a different MLR than the MLR calculated for risk corridor settlement purposes.

6.12.2.9 [Amendment #4:] The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

6.12.3 [Amendment #4:] The Granite Advantage Health Care Plan (GAHCP) risk corridor calculation shall be applied after the risk adjustment calculation.

6.12.3.1 [Amendment #4:] The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

7 TERMINATION OF AGREEMENT

7.1 Termination for Cause

7.1.1 DHHS shall have the right to terminate this Agreement, in whole or in part, without liability to the State, if the MCO:

7.1.1.1 Takes any action or fails to prevent an action that threatens the health, safety or welfare of any Member, including significant Marketing abuses;

7.1.1.2 Takes any action that threatens the fiscal integrity of the Medicaid program;

7.1.1.3 Has its certification suspended or revoked by any federal agency and/or is federally debarred or excluded from federal procurement and/or non-procurement agreement;

7.1.1.4 Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

7.1.1.5 Violates State or federal law or regulation;

7.1.1.6 Fails to carry out a substantive term or terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

7.1.1.7 Becomes insolvent;

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7.1.1.8 Fails to meet applicable requirements in Sections 1932, 1903 (m) and 1905(t) of the Social Security Act.; [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]

7.1.1.9 Receives a "going concern" finding in an annual financial report or indications that creditors are unwilling or unable to continue to provide goods, services or financing or any other indication of insolvency; or

7.1.1.10 Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily under Title 11 of the U.S. Code.

7.2 Termination for Other Reasons

7.2.1 The MCO shall have the right to terminate this Agreement if DHHS fails to make agreed-upon payments in a timely manner or fails to comply with any material term or condition of this Agreement, provided that, DHHS has not cured such deficiency within sixty (60) business days of its receipt of written notice of such deficiency.

7.2.2 This Agreement may be terminated for convenience by either the MCO or DHHS as of the last day of any month upon no less than one-hundred twenty (120) business days prior written notice to the other party.

7.2.3 Notwithstanding Section 7.2.2, this Agreement may be terminated immediately by DHHS if federal financial participation in the costs hereof becomes unavailable or if State funds sufficient to fulfill its obligations of DHHS hereunder are not appropriated by the Legislature. In either event, DHHS shall give MCO prompt written notice of such termination.

7.2.4 Notwithstanding the above, the MCO shall not be relieved of liability to DHHS or damages sustained by virtue of any breach of this Agreement by the MCO.

7.2.5 Upon termination, all documents, data, and reports prepared by the MCO under this Agreement shall become the property of and be delivered to DHHS immediately on demand.

7.2.6 DHHS may terminate this Agreement, in whole or in part, and place Members into a different MCO or provide Medicaid benefits through other Medicaid State Plan Authority, if DHHS determines that the MCO has failed to carry out the substantive terms of this Agreement or meet the applicable requirements of Sections 1932, 1903(m) or 1905(t) of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act].

7.2.6.1 In such event, Section 4.7.9 (Access to Providers During Transition of Care) shall apply.

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7.3 Claims Responsibilities

7.3.1 The MCO shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

7.3.2 The MCO shall be financially responsible for all other authorized services when the service is provided on or before the last day of the Closeout Period (defined in Section 7.7.3 (Service Authorization/Continuity of Care) below, or if the service is provided through the date of discharge.

7.4 Final Obligations

7.4.1 DHHS may withhold payments to the MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Such withheld payments may be used as a set-off and/or applied to the MCO's outstanding final financial obligations.

7.4.2 If all financial obligations of the MCO have been satisfied, amounts due to the MCO for unpaid premiums, risk settlement, High Dollar Stop Loss, shall be paid to the MCO within one (1) year of date of termination of the Agreement.

7.5 Survival of Terms

7.5.1 Termination or expiration of this Agreement for any reason shall not release either the MCO or DHHS from any liabilities or obligations set forth in this Agreement that:

7.5.1.1 The parties have expressly agreed shall survive any such termination or expiration; or

7.5.1.2 Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any such termination or expiration, or obliges either party by law or regulation.

7.6 Agreement Closeout

7.6.1 Period

7.6.1.1 DHHS shall have the right to define the close out period in each event of termination, and such period shall take into consideration factors such as the reason for the termination and the timeframe necessary to transfer Members.

7.6.1.2 During the closeout period, the MCO shall work cooperatively with, and supply program information to, any subsequent MCO and DHHS.

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7.6.1.3 Both the program information and the working relationships between the two MCOs shall be defined by DHHS.

7.6.2 Data

7.6.2.1 The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including but not limited to Encounter Data, to the new MCO and/or DHHS during the closeout period to ensure a smooth transition of responsibility.

7.6.2.2 The new MCO and/or DHHS shall define the information required from the MCO during this period and the time frames for submission.

7.6.2.3 All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied.

7.6.2.4 The MCO shall transmit the information and records required under this Section within the time frames required by DHHS.

7.6.2.5 DHHS shall have the right, in its sole discretion, to require updates to these data at regular intervals.

7.6.2.6 The MCO shall be responsible for continued submission of data to the CHIS during and after the transition in accordance with NHID regulations.

7.6.3 Service Authorization/Continuity of Care

7.6.3.1 Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with DHHS and/or its designee to process service authorization requests received.

7.6.3.1.1 Disputes between the MCO and DHHS and/or its designee regarding service authorizations shall be resolved by DHHS in its sole discretion.

7.6.3.2 The MCO shall give written notice to DHHS of all service authorizations that are not decided upon by the MCO within fourteen (14) calendar days prior to the last day of the closeout period.

7.6.3.2.1 Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

7.6.3.3 The Member has access to services consistent with the access they previously had, and is permitted to retain their current Provider for the period referenced in Section 4.7.9 (Access to

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Providers During Transitions of Care) for the transition timeframes if that Provider is not in the new MCO's network of Participating Providers.

7.6.3.4 The Member shall be referred to appropriate Participating Providers.

7.6.3.5 The MCO that was previously serving the Member, fully and timely complies with requests for historical utilization data from the new MCO in compliance with State and federal law.

7.6.3.6 Consistent with State and federal law, the Member's new Provider(s) are able to obtain copies of the Member's medical records, as appropriate.

7.6.3.7 Any other necessary procedures as specified by the HHS Secretary to ensure continued access to services to prevent serious detriment to the Member's health or reduce the risk of hospitalization or institutionalization.

7.6.3.8 DHHS shall make any other transition of care requirements publically available.



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Exhibit B Method and Conditions Precedent to Payment - Amendment #10

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit A. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

July 1, 2023 – August 31, 2024

Medicaid Care Management

Base Population

	Capitation Rate
Foster Care / Adoption Subsidy	\$428.42
Severely Disabled Children (DD & IHS)	1,682.15
Low Income Children - Age 0 - 11 months	404.28
Low Income Children - Age 1 - 18	197.72
Low Income Adults - Age 19+	487.49
Elderly and Disabled Adults - Age 19 - 64	1,433.61
Dual Eligibles (all dual rate cells)	278.83
Elderly and Disabled Adults - Age 65+	1,174.03
CHIP	186.44

Behavioral Health Population Rate Cells

Severe & Persistent Mental Illness: Dual	\$ 1,723.35
Severe & Persistent Mental Illness: Non Dual	2,374.70
Severe Mental Illness: Dual	1,137.10
Severe Mental Illness: Non Dual	1,666.72
Low Utilizer - Dual	684.24
Low Utilizer - Non Dual	1,650.59
SED Child - TANF and Foster Care	1,117.54

Medicaid Expansion

Medically Frail	\$1,106.91
Non-Medically Frail	483.31

Maternity/Newborn Kick Payments

Maternity kick Payment	\$ 3,385.41
Newborn kick Payment	6,762.03
Neonatal Abstinence Syndrome kick Payment	21,023.17



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Exhibit B Method and Conditions Precedent to Payment - Amendment #10

For each of the subsequent years of the Agreement, actuarially sound per Member, per month capitated rates shall be paid as calculated and certified by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

Any rate adjustments shall be subject to the availability of State appropriations.

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for the fourteen month contract period covering State Fiscal Year 2024, July 1, 2023 – June 30, 2024, and State Fiscal Year 2025 July 1, 2024 – August 31, 2024 to be served among all contracts is 2,499,560. Accordingly, the price limitation for the fourteen month contract period July 1, 2023 – August 31, 2024 among all contracts is \$ 1,209,229,580 based on the projected members per month. The full price limitation is \$ 5,928,058,454.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

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EXHIBIT O – Quality and Oversight Reporting Requirements Amendment #10

1. General

- 1.1. The list of deliverables in Exhibit O provides a high-level summary of what each deliverable will entail. *Please note all information is subject to revision and refinement as NH DHHS finalizes the specifications for each deliverable.*
- 1.2. The Exhibit O measures/measure sets, logs, and narrative reports shall be submitted according to the specified schedule. Submission formats shall either be the standard HEDIS submission format for HEDIS measures or as specified by NH DHHS for other measures, data tables and reports.
- 1.3. NH DHHS utilizes measures from several measure stewards, including NCQA and the Pharmacy Quality Alliance (PQA). The MCO is responsible for contracting with these entities or associated vendors as appropriate for producing deliverables.
- 1.4. To help insure the successful generation of consistent Exhibit O deliverables (both over time for each MCO and across all MCOs), the following processes will be in place.
 - 1.4.1. NH DHHS shall:
 - 1.4.1.1. Identify specifications for each deliverable;
 - 1.4.1.2. Engage the MCOs in the development of measures as appropriate;
 - 1.4.1.3. Schedule "Exhibit O" meetings (webinars, typically held on Friday afternoons) with the MCOs to:
 - 1.4.1.3.1. Review all deliverable specifications;
 - 1.4.1.3.2. Provide clarifications as needed by the MCOs;
 - 1.4.1.3.3. Establish initial due dates for all deliverables.
 - 1.4.1.4. Provide training for use of the NH Medicaid Quality Information System (MQIS) and the DHHS SharePoint site;
 - 1.4.1.5. Contact MCO compliance staff to validate suspected reporting discrepancies.
 - 1.4.2. MCO compliance staff and appropriate subject matter experts (SMEs) shall:
 - 1.4.2.1. Review, sign, and comply with all applicable DHHS and DoIT applicable policies and procedures;
 - 1.4.2.2. Review all specifications for clarity and request more information as needed;
 - 1.4.2.3. Participate in measure development activities as appropriate;
 - 1.4.2.4. Participate in the "Exhibit O" meetings;
 - 1.4.2.5. Follow the finalized specifications for submission of deliverables;
 - 1.4.2.6. Gain access to and utilize the MQIS, including participation in any DHHS required training necessary;
 - 1.4.2.7. Submit all data as required to MQIS using MQIS specified formats;
 - 1.4.2.8. Submit deliverables as required to the DHHS SharePoint site;
 - 1.4.2.9. Respond to system generated error reports;

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**EXHIBIT O – Quality and Oversight Reporting Requirements
 Amendment #10**

1.4.2.10. Respond to requests from DHHS staff to validate suspected reporting discrepancies.

1.5. The Department reserves the right to develop and require alternative methodologies to submit data.

2. Key Definitions

2.1. The following terms include some of the unique or new terms found in Exhibit O. Please reference Exhibit A for more details.

Term	Definition
2.1.1. Community Hospital	Any hospital other than New Hampshire Hospital
2.1.2. Community Mental Health Program or CMHP, High Risk / High Need, Local Care Management, and Priority Populations	As defined in Exhibit A.
2.1.3. Subpopulations	<p>Subpopulations consist of components used together to classify a member and are used for selected measures as indicated in the NH Medicaid Care Management Quality and Oversight Reporting Deliverables table below.</p> <p>General subpopulations utilize the following components: Age Group, Member Type, LTSS Type, and Payer Type. Measures use specific components in conjunction based on the measurement intent.</p> <p>Each component is broken down into the following categories that have standardized definitions used consistently across all measures:</p> <ul style="list-style-type: none"> • Age Group (<i>Children, Adults, Older Adults</i>), • Member Type (<i>DCYF Involved Child, Child with Severe Disabilities (HC-CSD, SSI, SMS), Other Special Needs Child, Other Child, Special Needs Adult, All Other Adults, All Older Adults</i>), • LTSS Type (<i>Receiving LTC Services (Waiver or Nursing Home), Eligible for CMHC Services and Not Also Waiver/Nursing Home, Not Receiving Waiver, CMHC, or Nursing Home</i>), and • Payer Type (<i>Medicaid Primary, Medicare Primary, Other Primary</i>)

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
ACCESSREQ.05	Requests for Assistance Accessing MCO Designated Primary Care Providers by County	Count and percent of member telephone and/or email requests for assistance accessing MCO Designated Primary Care Providers (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer appearing on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		
ACCESSREQ.06	Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County	Count and percent of member telephone and/or email requests for assistance accessing non-MCO Designated Physician/APRN Specialists (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period							X	
AMBCARE.10	Physician/APRN/Clinic Visits	Count and percent of Physician/APRN/Clinic visits per 1,000 member months by subpopulation.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
AMBCARE.11	Emergency Department Visits for Physical Health Conditions	Count and percent of Ambulatory emergency department (ED) visits per 1,000 member months by subpopulation. This measure excludes ED visits for mental health and substance use disorder/substance misuse conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.12	Emergency Department Visits - Potentially Treatable in Primary Care	Count and percent of Ambulatory emergency department visits for conditions potentially treatable in primary care per 1,000 member months by subpopulation.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.13	Emergency Department Visits - Mental Health Conditions	Count and percent of Ambulatory emergency department (ED) visits for mental health conditions per 1,000 member months by subpopulation. This measure excludes ED visits for substance use disorder/substance misuse conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X	X	
AMBCARE.14	Emergency Department Visits - Substance Use Disorder and Substance Misuse Related Conditions	Count and percent of Ambulatory emergency department visits for substance use disorder (SUD) and substance misuse related conditions per 1,000 member months by subpopulation. This measure excludes ED visits for mental health conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.18	Frequent Emergency Department Use	Count and percent of members with frequent ED use in the previous 12 months, by subpopulation. Frequent ED use is defined as 4+ visits in a 12-month period. This measure includes ED visits for physical health, mental health and substance use disorder/substance misuse conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.20	Emergency Department Visits for Any Condition by Subpopulation	Count and percent of all Ambulatory emergency department (ED) visits for Medical Health, Behavioral Health and Substance Use Related (Chronic or Acute) Conditions (Total counts, not broken out by condition group).	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X	X	

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
ANNUALRPT.01	Medicaid Care Management Program Comprehensive Annual Report	The annual report is the Managed Care Organization's PowerPoint presentation on the accomplishments and opportunities of the prior agreement year. The report will address how the MCO has impacted Department priority issues, social determinants of health, improvements to population health, and developed innovative programs. The audience will be the NH Governor, legislature, and other stakeholders.	Narrative Report		Agreement Year	Annually	August 30th						X		X
APM.01	Alternative Payment Model Plan	Implementation plan that meets the requirements for Alternative Payment Models outlined in the MCM Model Contract and the Department's Alternative Payment Model Strategy.	Plan		Varies	Annually	May 1st								X
APM.02	Alternative Payment Model Quarterly Update	Standard template showing the quarterly results of the alternative payment models.	Table		Varies	Quarterly	4 Months after end of Measurement Period								X
APM.03	Alternative Payment Model Completed HCP-LAN Assessment Results	The HCP-LAN Assessment is available at: https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf ; the MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).	Narrative Report		Varies	Annually	October 31st								X
APPEALS.01	Resolution of Standard Appeals Within 30 Calendar Days	Count and percent of appeal resolutions of standard appeals within 30 calendar days of receipt of appeal for appeals filed with the MCO during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.02	Resolution of Extended Standard Appeals Within 44 Calendar Days	Count and percent of appeal resolutions of extended standard appeals within 44 calendar days of receipt of appeal for appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
APPEALS.03	Resolution of Expedited Appeals Within 72 Hours	Count and percent of appeal resolutions of expedited appeals within 72 hours of receipt of appeal for appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.04	Resolution of All Appeals Within 45 Calendar Days	Count and percent of appeal resolutions within 45 calendar days of receipt of appeal for appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.05	Resolution of Appeals by Disposition Type	Count and percent of appeals where member abandoned appeal, MCO action was upheld, or MCO action was reversed for all appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.16	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Standard template that provides counts of MCO resolved appeals by resolution type (i.e. upheld, withdrawn, abandoned) by category of service. The counts are broken out by State Plan and 1915B waiver populations.	Table		Quarter	Quarterly	2 Months after end of Measurement Period				X	X	X		
APPEALS.17	Pharmacy Appeals by Type of Resolution and Therapeutic Drug Class by State Plan, 1915B Waiver, and Total Population	Standard template providing counts of MCO appeals resolutions by resolution type and category of pharmacy class	Table		Quarter	Quarterly	2 Months after end of Measurement Period				X	X	X		
APPEALS.18	Services Authorized within 72 Hours Fol03 - Lowing a Reversed Appeal	Count and percent of services authorized within 72 hours fol03 - Lowing a reversed appeal for the service that was previously denied, limited or delayed by the MCO.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.19	Member Appeals Received	Count and percent of Member appeals filed during the measurement data period, per 1,000 member months.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD-Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
BHDRUG.01	Severe Mental Illness Drug Prior Authorization Report	Standard template to monitor MCO pharmacy service authorizations (SA) for drugs to treat severe mental illness that are prescribed to members receiving services from Community Mental Health Programs. The report includes aggregate data detail related to SA processing timeframes, untimely processing rates, peer-to-peer activities, SA approval and denial rates. The report also includes a log of member specific information related to SA denials.	Table		Quarter	Quarterly	1 Month after end of Measurement Period								X
BHPARITY.01	Behavioral Health Parity Attestation	Standard report for MCO to attest to compliance with behavioral health parity requirements.	Table		Calendar Year	Annually	January 31st						X		X
BHSTRATEGY.01	Behavioral Health Strategy Plan and Report	Annual comprehensive plan describing the MCOs policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers.	Plan		Agreement Year	Annually	May 15th							X	X
BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report	Standard template to report the results of the annual behavioral health consumer satisfaction survey for members with mental health and substance use disorder (SUD) conditions. The report includes all mandatory questions for the survey.	Table		Calendar Year	Annually	June 30th	X							

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAHPS_A.01	Adult CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the Adult Medicaid CAHPS 5.0 survey population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCOA can report the data. Please reference HEDIS® Volume 3; Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X		X			X		
CAHPS_A.02	Adult CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the Adult Medicaid CAHPS 5.0H Validated Member Level Data File.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X		X			X		
CAHPS_A.03	Adult CAHPS: Medicaid Adult Survey Results Report	This report includes summary information about the Adult Medicaid CAHPS 5.0H survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X		X			X		
CAHPS_A.04	Adult CAHPS: CAHPS Survey Results with Confidence Intervals	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X		X			X		
CAHPS_A.05	Adult CAHPS: Survey Instrument Proofs created by Survey Vendor	Adult Medicaid CAHPS 5.0H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	Feb 28th	X		X			X		

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/MD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAHPS_A_SUP	Adult CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure		Standard HEDIS Schedule	Annually	July 31st	X					X		X
CAHPS_CCC.01	Child w CCC CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the CAHPS Medicaid Child with CCC 5.0H survey population. This file will include respondents identified as either General Population, or Child with Chronic Conditions (Child with CCC) Population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS* Volume 3, Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
CAHPS_CCC.02	Child w CCC CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the CAHPS Child with CCC 5.0H Survey Validated Member Level Data File.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
CAHPS_CCC.03	Child w CCC CAHPS: Medicaid Child with CCC - CCC Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID.	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD/Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAHPS_CCC.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - Child with CCC	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X	X				X		
CAHPS_CCC.05	Child w CCC CAHPS: Survey Instrument Proofs created by Survey Vendor	CAHPS Child with CCC 5.0H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	Feb 28th	X	X				X		
CAHPS_CCC_SUP	Child CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure		Standard HEDIS Schedule	Annually	July 31st	X					X		X
CAHPS_CGP.03	Child w CCC CAHPS: Medicaid Child with CCC - General Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
CAHPS_CGP.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - General Population	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X	X				X		

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CARECOORD.03	Neonatal Abstinence Syndrome Referrals to Care Management	Count and percent of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) during the measurement quarter referred to case management within 30 calendar days of diagnosis.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
CARECOORD.04	Neonatal Abstinence Syndrome Engagement in Care Management	Count and percent of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) during the measurement quarter who enrolled with the MCO care management program within 30 days of the referral.	Measure		Quarter	Quarterly	5 Months after end of Measurement Period								X
CAREMGT.01	Care Management Plan Including Plan to Assess and Report on the Quality and Appropriateness of Care Furnished to Members With Special Health Care Needs	Overview of the MCO plan to implement and operate their comprehensive care management program for the next agreement year.	Plan		Agreement Year	Annually	May 1st								X
CAREMGT.23	Care Management Comprehensive Assessments Completed by Subcontractor Entity	Percent of completed comprehensive assessments in the quarter completed by a subcontractor entity.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.24	Care Management: Comprehensive Assessment Attempts Completed Within 30 Days	Count and percent of members requiring a comprehensive assessment within 30 days of being identified as requiring this assessment, by outcome of MCO completion attempts.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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CAREMGT.25	Care Management Comprehensive Assessment Results within 14 Calendar Days	Percent of members with a comprehensive assessment completed during the measurement quarter, where the assessment results were shared in writing with members of the local-based care team within 14 calendar days of being established. The local-based care team includes but is not limited to the member's PCP, specialist, behavioral health provider, and local care management entity.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period									X
CAREMGT.26	Care Management Resources - Unmet Needs	Standard template aggregating by county, resource needs (e.g. housing supports, providers) that cannot be met because they are not locally available. Data will be based on the care screening and comprehensive assessments conducted during the quarter.	Table		Quarter	Quarterly	2 Months after end of Measurement Period									X
CAREMGT.28	Care Management: Members Receiving Care Management by Priority Population	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by priority populations outlined in the Care Coordination and Care Management section of the MCM Contract. Enrollment in care management is defined as the member having a completed plan of care.	Table		Quarter	Quarterly	4 Months after end of Measurement Period									X
CAREMGT.29	Care Management Outreach to High-Risk/High-Need Members	Count and percent of members who received outreach from the MCO to enroll in care management within 30 calendar days of being identified as High-risk or High-need through a completed comprehensive assessment, by the outcome of MCO outreach.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period									X
CAREMGT.32	Members Receiving Face-to-Face Local Care Management	Count and percent of members enrolled in local care management during the measurement quarter, who had at least one face-to-face meeting with their local case manager or designee during the quarter.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period									X

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CAREMGT.39	Members Enrolled in Care Management	Count and percent of members enrolled in care management on the last day of the month. Enrollment in care management is defined as the member having a completed plan of care.	Measure		Month	Monthly	1 Month after end of Measurement Period					X			X
CAREMGT.40	Members Enrolled in Care Management at Any Time During the Month	Count and percent of members enrolled in care management at any time during the month. Enrollment in care management is defined as the member having a completed plan of care.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.41	Members Receiving Local Care Management by Geographic Region	Count and percent of members who are enrolled in care management and receiving local care management at the end of the measurement month, by geographic region.	Measure		Month	Monthly	1 Month after end of Measurement Period								X
CAREMGT.42	Members Identified as High-Risk/High-Need Receiving Care Management	Count and percent of members identified as "High-risk"/"High-need" through the comprehensive assessment completed in the measurement quarter, who enrolled in care management within 30 calendar days of completion of the comprehensive assessment.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.43	Members Receiving Care Management by Geographic Region	Count and percent of members who are enrolled in care management at the end of the measurement month, by geographic region.	Measure		Month	Monthly	1 Month after end of Measurement Period								X

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CAREMGT.44	Successful Member Welcome Calls	<p>Count and percent of members newly enrolled in an MCO during the measurement period for whom the MCO completed a welcome call within 30 calendar days of enrollment. The welcome call contract requirements are as follows:</p> <ul style="list-style-type: none"> • The MCO shall make a welcome call to each New Member within thirty (30) calendar days of the Member's enrollment in the MCO. • The welcome call shall, at a minimum: <ul style="list-style-type: none"> o Assist the Member in selecting a PCP or confirm selection of a PCP; o Arrange for a wellness visit with the Member's PCP (either previously identified or selected by the Member from a list of available PCPs), which shall include: <ul style="list-style-type: none"> o Assessments of both physical and behavioral health, o Screening for depression, mood, suicidality, and Substance Use Disorder, and o Development of a health, wellness and care plan; o Include a Health Risk Assessment Screening as required in Section 4.10.2.2, or schedule the Health Risk Assessment to be conducted within the time limits identified in this Agreement; o Screen for special needs, physical and behavioral health, and services of the Member; o Answer any other Member questions about the MCO; o Ensure Members can access information in their preferred language; and o Remind Members to report to DHHS any change of address, as Members shall be liable for premium payments paid during period of ineligibility. 	Measure	Quarter	Quarterly	3 Months after end of Measurement Period							X
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CAREMGT.45	New Member Welcome Calls – MCO Arranged Wellness Visit	Count and percent of members newly enrolled in an MCO during the measurement period for whom the MCO completed a welcome call within 30 calendar days of enrollment and arranged a wellness visit for the member or other covered family member, broken out by the results of the wellness visit conversation. • MCO Arranged Wellness Visit • Member Declined MCO Assistance to Arrange Wellness Visit • Member Wanted Assistance to Arrange Wellness Visit but MCO was Unable to Arrange Visit • MCO Did Not Offer to Arrange Wellness Visit	Measure		Quarter	Quarterly	3 Months after end of Measurement Period									X
CAREMGT.46	New Member Wellness Visits – Visit Occurred	Count and percent of members newly enrolled in an MCO during the measurement period where the member had a wellness visit within 6 months of their enrollment date.	Measure		Quarter	Quarterly	10 Months after end of Measurement Period									X
CLAIM.08	Interest on Late Paid Claims	Total interest paid on professional and facility claims not paid within 30 calendar days of receipt using interest rate published in the Federal Register in January of each year for the Medicare program. Note: Claims include both Medical and Behavioral Health claims.	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period						X			X
CLAIM.11	Professional and Facility Medical Claim Processing Results	Count and percentage of professional and facility medical claims received in the measurement period, with processing status on the last day of the measurement period that are Paid, Suspended, or Denied.	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period						X			X

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CLAIM.17	Average Pharmacy Claim Processing Time	The average pharmacy claim processing time per point of service transaction, in seconds. The contract standard in Amendment 7, section 14.1.9 is: The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds. Note: Claims include both Medical and Behavioral Health claims.	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period						X		X
CLAIM.21	Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt	Count and percent of clean electronic provider claims processed within 15 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period					X	X		X
CLAIM.22	Timely Processing of Non-Electronic Provider Claims: Thirty Days of Receipt	Count and percent of clean non-electronic provider claims processed within 30 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period					X	X		X
CLAIM.23	Timely Processing of All Clean Provider Claims: Thirty Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period					X	X		X

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CLAIM.24	Timely Processing of All Clean Provider Claims: Ninety Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 90 calendar days of receipt of the claim, for those received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT) claims.	Measure		Month	Monthly	110 Calendar Days after end of Measurement Period						X		X
CLAIM.25	Claims Quality Assurance - Claims Payment Accuracy	Sampled percent of all provider claims that are paid or denied correctly during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure		Quarter	Quarterly	50 Calendar Days after end of Measurement Period					X	X		X
CLAIM.26	Claims Quality Assurance: Claims Financial Accuracy	Sampled percent of dollars accurately paid for provider claims during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims. Note: It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.	Measure		Quarter	Quarterly	50 Calendar Days after end of Measurement Period					X	X		X

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CLAIM.27	Claims Quality Assurance: Claims Processing Accuracy	Sampled percent of all provider claims that are accurately processed in their entirety from both a financial and non-financial perspective during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure		Quarter	Quarterly	50 Calendar Days after end of Measurement Period					X	X		X
CMS_A_AMM.01	Antidepressant Medication Management: Effective Acute Phase Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS AMM measure.	Measure		May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	September 30th			X					
CMS_A_AMM.02	Antidepressant Medication Management: Effective Continuation Phase Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS AMM measure.	Measure		May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	September 30th			X					
CMS_A_AMR	Asthma Medication Ratio	CMS Adult Core Set - Age breakout of data collected for HEDIS AMR measure.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_BCS	Breast Cancer Screening	CMS Adult Core Set - Age breakout of data collected for HEDIS BCS measure.	Measure		2 Calendar Years	Annually	September 30th			X					

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CMS_A_CBP	Controlling High Blood Pressure	CMS Adult Core Set - Age breakout of data collected for HEDIS CBP measure.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_CCP.01	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days	CMS Adult and Child Core Sets - The percentage of women ages 15 through 44 who had a live birth and were provided a most or moderately effective method of contraception within 3 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_CCP.02	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a most or moderately effective method of contraception within 60 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_CCP.03	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 3 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_CCP.04	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 60 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 60 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_CDF	Screening for Clinical Depression and Follow-up Plan	CMS Adult and Child Core Sets (member age determines in which set the member is reported)	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_COL	Colorectal Cancer Screening	CMS Adult Core Set - Age breakout of data collected for HEDIS COL measure.	Measure		Calendar Year with a 10 Year Look-back	Annually	September 30th			X					
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set - Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	Measure		Calendar Year	Annually	September 30th			X	X				

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CMS_A_FUA.01	Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Within 7 Days of ED Visit	CMS Adult Core Set - Age breakout of data collected for HEDIS FUA measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_FUA.02	Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Within 30 Days of ED Visit	CMS Adult Core Set - Age breakout of data collected for HEDIS FUA measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_HBD.01	Hemoglobin A1c Control for Patients With Diabetes - HbA1c control (<8.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c control (<8.0%).	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_HBD.02	Hemoglobin A1c Control for Patients With Diabetes - HbA1c poor control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c poor control (>9.0%).	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for a former HEDIS measure.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_IET.01	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.02	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				

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CMS_A_IET.03	Initiation of Alcohol Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.04	Engagement of Alcohol Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.05	Initiation of Opioid Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.06	Engagement of Opioid Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.07	Initiation of Other Drug Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.08	Engagement of Other Drug Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_INP_PQI01	Diabetes Short-Term Complication Admissions	CMS Adult Core Set - Diabetes Short-Term Complications Admission Rate per 100,000 Member Months	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_INP_PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions	CMS Adult Core Set - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_INP_PQI08	Heart Failure Admissions	CMS Adult Core Set - Heart Failure Admission Rate per 100,000 Enrollee Months	Measure		Calendar Year	Annually	September 30th			X					

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CMS_A_INP_PQ115	Asthma in Younger Adults Admissions	CMS Adult Core Set - Asthma in Younger Adults Admission Rate per 100,000 Enrollee Months	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_MSC.01	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_MSC.02	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_MSC.03	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_OHD	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage	CMS Adult Core Set - The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.01	Use of Pharmacotherapy for Opioid Use Disorder - Total	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed medication for the disorder.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.02	Use of Pharmacotherapy for Opioid Use Disorder - Buprenorphine	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Buprenorphine.	Measure		Calendar Year	Annually	September 30th			X	X				

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CMS_A_OUD.03	Use of Pharmacotherapy for Opioid Use Disorder - Oral Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Oral Naltrexone.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.04	Use of Pharmacotherapy for Opioid Use Disorder - Long-Acting, Injectable Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Long-Acting, Injectable Naltrexone.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.05	Use of Pharmacotherapy for Opioid Use Disorder - Methadone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Methadone.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_CCW.01	Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_CCW.02	Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_CH_DEV	Developmental Screening in the First Three Years of Life	CMS Child Core Set - Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Measure		Calendar Year	Annually	September 30th		X						

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CULTURALCOMP.01	Cultural Competency Strategic Plan	MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by communication access utilization reports, quality improvement data disaggregated by race, ethnicity and language, and the community assessments and profiles.	Plan		Agreement Year	Annually	May 1st								X
DUR.01	Drug Utilization Review (DUR) Annual Report	This annual report includes Center for Medicaid and Medicaid Services (CMS) required information on the operation of the MCO's Medicaid DUR Program.	Narrative Report		Federal Fiscal Year	Annually	May 15th						X		X
EMERGENCY RESPONSE.01	Emergency Response Plan	Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs, including, but not limited to, specific pandemic and natural disaster preparedness. After the initial submission of the plan the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.	Plan		Agreement Year	Annually	May 1st								X
EPSDT.01	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	Standard template that captures the total paid units of each of the ABA services by member for the purpose of fiscal impact analysis.	Table		Quarter	Quarterly	4 Months after end of Measurement Period.								X

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EPSDT.20	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	MCO EPSDT plan includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure provider network compliance that all members under age 21 receive all the elements of the preventive health screenings recommended by the AAP's most currently published Bright Futures guidelines for well-child care in accordance with the EPSDT periodicity schedule. Additionally, the MCO EPSDT plan must include written policies and procedures for the provision of a full range of EPSDT diagnostic and treatment services.	Plan		Agreement Year	Annually	May 1st								X
EQRO.01	MCO Follow-up on EQRO Recommendations	This semi-annual report will provide a description of actions taken to address select MCO-specific findings/recommendations identified by NH EQRO quality reports.	Narrative Report		6 Months	Semi-Annually	1 Month after end of Measurement Period								X
FINANCIALSTMT.01	MCO Annual Financial Statements	The MCO shall provide DHHS a complete copy of its audited financial statements and amended statements.	Narrative Report		MCO Financial Period	Annually	August 10th								X
FWA.02	Fraud Waste and Abuse Log: FWA Related to Providers	Standard template log of all Fraud Waste and Abuse related to providers, in process and completed during the month by the MCO or its subcontractors. This log includes but is not limited to case information, current status, and final outcome for each case including overpayment and recovery information.	Table		Month	Monthly	1 Month after end of Measurement Period						X		X
FWA.04	Fraud Waste and Abuse Log: Date of Death Report	Standard template that captures a list of members who expired during the measurement period.	Table		Month	Monthly	1 Month after end of Measurement Period						X		X

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FWA.05	Fraud Waste and Abuse Log: Explanation Of Medical Benefit Report	Standard template that includes a summary explanation of medical benefits sent and received including the MCO's follow-up, action/outcome for all EMB responses that required further action.	Table		Quarter	Quarterly	1 Month after end of Measurement Period						X		X
FWA.06	Fraud Waste and Abuse Log: Waste Recovery Report	Standard template reporting waste identified and recovered by the MCO.	Table		Quarter	Quarterly	1 Month after end of Measurement Period								X
FWA.20	Comprehensive Annual Prevention of Fraud Waste and Abuse Summary Report	The MCO shall provide a summary report on MCO Fraud, Waste and Abuse investigations. This should include a description of the MCO's special investigation's unit. The MCO shall describe cumulative overpayments identified and recovered, investigations initiated, completed, and referred, and an analysis of the effectiveness of activities performed. The MCO's Chief Financial Officer will certify that the information in the report is accurate to the best of his or her information, knowledge, and belief.	Narrative Report		Agreement Year	Annually	September 30th						X		X
GRIEVANCE.02	Grievance Log Including State Plan / 1915B Waiver Flag	Standard template log of all grievances with detail on grievances and any corrective action or response to the grievance for grievances made within the measure data period.	Table		Quarter	Quarterly	15 Calendar Days after end of Measurement Period			X	X	X			
GRIEVANCE.03	Member Grievances Received	Count and Percent of member grievances received during the measure data period, per 1,000 member months.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		
GRIEVANCE.05	Timely Processing of All Grievances	Count and percent of grievances processed within contract timeframes for grievances made during the measurement period.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period	X					X		

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HEDIS.01	HEDIS Roadmap	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
HEDIS.02	HEDIS Data Filled Workbook	Workbook containing the NCOA audited results for all HEDIS measures, with one measure appearing on each tab.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
HEDIS.03	HEDIS Comma Separated Values Workbook	This file includes NCOA audited results for all HEDIS measures, and should include the Eligible Population and/or Denominator, Numerator, Rate, and Weight (for hybrid measures) for each measure.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
HEDIS.04	NCOA HEDIS Compliance Audit™ Final Audit Report	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X	X				X		
HEDIS.06	HEDIS Member Level Data	This file contains member/event level data for select HEDIS measures. Data will reflect the NCOA audited results for these measures in the corresponding HEDIS Data-Filled Workbook for the same measurement period. The current list of DHHS-selected HEDIS measures appears in <i>Appendix AF - HEDIS Measures Included in HEDIS.06</i> and is subject to change each measurement year.	HEDIS/CAHPS Files		Calendar Year	Annually	June 30th								

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HEDIS_AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	HEDIS Measure, also utilized for CMS Core Sets	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X	X	X					
HEDIS_ADD	Follow-Up Care for Children Prescribed ADHD Medication	HEDIS Measure, also utilized for CMS Core Sets	Measure		One year starting March 1 of year prior to measurement year to February 28 of measurement year.	Annually	June 30th	X	X						X
HEDIS_AIS-E	Adult Immunization Status - Influenza, Td/Tdap, Zoster, Pneumococcal	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_AMB	Outpatient and Emergency Dept. Visits/1000 Member Months	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th		X			X			X

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HEDIS_AMM	Antidepressant Medication Management	HEDIS Measure, also utilized for CMS Core Sets	Measure		May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	June 30th	X		X					X
HEDIS_AMR	Asthma Medication Ratio	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X	X					
HEDIS_APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_AXR	Antibiotic Utilization for Respiratory Conditions (AXR)	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_BCS	Breast Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure		2 Calendar Years	Annually	June 30th	X		X					X
HEDIS_BCS-E	Breast Cancer Screening	HEDIS Measure	Measure		2 Calendar Years	Annually	June 30th	X							X
HEDIS_BPD	Blood Pressure Control (<140/90) (BPD)	HEDIS Measure formerly part of HEDIS_CDC, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th	X							X
HEDIS_CBP	Controlling High Blood Pressure	HEDIS Measure. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th	X		X					X

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HEDIS_CCS	Cervical Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure		3 Calendar Years	Annually	June 30th	X		X					X
HEDIS_CHL	Chlamydia Screening in Women	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X	X					X
HEDIS_CIS	Childhood Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_COL	Colorectal Cancer Screening (COL)	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year with a 10 Year Look-back	Annually	June 30th			X					
HEDIS_COU	Risk of Chronic Opioid Use (COU)	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X			X				X
HEDIS_CRE	Cardiac Rehabilitation	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_CWP	Appropriate Testing for Pharyngitis	HEDIS Measure	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X							
HEDIS_EED	Eye Exam for Patients With Diabetes (EED)	HEDIS Measure formerly part of HEDIS_CDC, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th	X							X
HEDIS_FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure		Calendar Year	Annually	June 30th	X	X	X	X				X

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HEDIS_FUH	Follow-Up After Hospitalization For Mental Illness	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure		January 1 to December 1 of measurement year	Annually	June 30th	X	X	X					X
HEDIS_FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure		January 1 to December 1 of measurement year	Annually	June 30th	X							X
HEDIS_FUM	Follow-Up After Emergency Department Visit for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure		Calendar Year	Annually	June 30th	X	X	X					X
HEDIS_FVA	Flu Vaccinations for Adults Ages 18–64 (FVA)	HEDIS Measure Collected through the CAHPS Health Plan Survey, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					
HEDIS_HBD	Hemoglobin A1c Control for Patients With Diabetes (HBD)	HEDIS Measure formerly part of HEDIS_CDC. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th	X		X					X
HEDIS_HDO	Use of Opioids at High Dosage	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X			X				X
HEDIS_IET	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure		Calendar Year	Annually	June 30th	X		X	X				X
HEDIS_IMA	Immunizations for Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_KED	Kidney Health Evaluation for Patients with Diabetes	HEDIS Measure, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th	X							X
HEDIS_LBP	Use of Imaging Studies for Low Back Pain	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							

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HEDIS_LSC	Lead Screening in Children	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th		X						X
HEDIS_MSC	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	HEDIS Measure Collected through the CAHPS Health Plan Survey	Measure		Calendar Year	Annually	June 30th	X		X					
HEDIS_PCE	Pharmacotherapy Management of COPD Exacerbation	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_PCR	Plan All-Cause Readmissions	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					X
HEDIS_POD	Pharmacotherapy for Opioid Use Disorder	HEDIS Measure	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X							X
HEDIS_PPC	Prenatal and Postpartum Care	HEDIS Measure, also utilized for CMS Core Sets. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th	X	X	X					X
HEDIS_PRS-E	Prenatal Immunization Status	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_RDM	Race/Ethnicity Diversity of Membership	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_SAA	Adherence to Antipsychotics for Individuals with Schizophrenia	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					X

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HEDIS_SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_SPC	Statin Therapy for Patients with Cardiovascular Disease	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_SPD	Statin Therapy for Patients with Diabetes	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					X
HEDIS_UOP	Use of Opioids from Multiple Providers	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X			X				X
HEDIS_UR1	Appropriate Treatment for Upper Respiratory Infection	HEDIS Measure	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X							
HEDIS_W30	Well-Child Visits in the first 30 Months of Life	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th		X				X		X

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HEDIS_WCC	Weight Assessment and Counseling	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_WCV	Child and Adolescent Well-Care Visits	HEDIS Measure, also utilized for CMS Core Sets Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th		X				X		X
HRA.08	Successful Completion of MCO Health Risk Assessment	Percent of members for whom the MCO shows completion of a health risk assessment during the measurement year, as of the last day of the measurement year. This measure excludes members newly eligible for Medicaid in the last three months of the measurement year.	Measure		Year	Quarterly	2 Months after end of Measurement Period								
HRA.09	Health Risk Assessment Narrative Report	Narrative description of the MCO's efforts to assure 25% of the members have a completed Health Risk Assessment including reasons for not achieving the contract standard.	Narrative Report		Quarter	Quarterly	2 Months after end of Measurement Period								
IMDDISCHARGE.01	State of NH IMD Hospital Discharges - Member Received Discharge Instruction Sheet	Count and percent of discharges from a State of NH IMD Hospital where the member received a discharge instruction sheet upon discharge.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
IMDDISCHARGE.02	State of NH IMD Hospital Discharges - Discharge Plan Provided to Aftercare Provider Within 7 Calendar Days of Member Discharge	Count and percent of members discharged from a State of NH IMD Hospital where the discharge progress note was provided to the aftercare provider within 7 calendar days of member discharge. The contract standard = at least ninety percent (90%) of members discharged.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X

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IMDDISCHARGE.03	State of NH IMD Hospital Discharges - New CMHC Patient Had Intake Appointment with CMHC within 7 Calendar Days of Discharge	Count and percent of State of NH IMD Hospital discharges where the patient had an intake appointment with a NH Community Mental Health Center (NH CMHC) within 7 calendar days of discharge AND who were new to the NH CMHC system.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
IMDDISCHARGE.04	State of NH IMD Hospital Discharges - MCO Contacts and Contact Attempts	Count and percent of members discharged from a State of NH IMD Hospital during the measurement period, where the MCO either successfully contacted the member, or attempted to contact the member at least 3 times, within 3 business days of discharge.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
IMDDISCHARGE.05	Follow-up Visit after Discharge from a State of NH IMD Hospital - Within 7 Days of Discharge	Count and percent of member discharges from a State of NH IMD Hospital where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge, by age group and CMHC eligibility. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
IMDDISCHARGE.06	Follow-up Visit after Discharge from a State of NH IMD Hospital - Within 30 Days of Discharge	Count and percent of member discharges from a State of NH IMD Hospital where the member had at least one follow-up visit with a mental health practitioner within 30 calendar days of discharge, by age group and CMHC eligibility. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
IMDREADMIT.01	Readmissions to State of NH IMD Hospital - Within 30 Days of Discharge	Count and percent of member readmissions to a State of NH IMD Hospital within 30 days of discharge, by age group and CMHC eligibility.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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IMDREADMIT.02	Readmissions to State of NH IMD Hospital - Within 180 Days of Discharge	Count and percent of member readmissions to a State of NH IMD Hospital within 180 days of discharge, by age group and CMHC eligibility.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
IMDREADMIT.03	ED Visits for Mental Health Preceded by a State of NH IMD Hospital Stay in Past 30 Days	Count and percent of mental health related emergency department visits that were preceded within 30 days by a discharge from a State of NH IMD Hospital and not followed by a readmission to a State of NH IMD Hospital, for continuously enrolled Medicaid members, by age group and CMHC eligibility. The primary diagnosis for the ED visit must be mental health related.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
INLIEUOF.01	In Lieu of Services Report	A narrative report describing the cost effectiveness of each approved In Lieu of Service by evaluating utilization and expenditures.	Narrative Report		Agreement Year	Annually	November 1st						X		X

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INPASC.04	Inpatient Hospital Utilization - Ambulatory Care Sensitive Conditions	Count and percent of Inpatient hospital utilization for ambulatory care sensitive conditions per 1,000 adult member months, by subpopulation. This measure includes the following ambulatory care sensitive conditions, as defined for the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators Overall Composite (PQI #90): Diabetes Short-Term Complications (PQI #1); Diabetes Long-Term Complications (PQI #3); Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (PQI #5); Hypertension (PQI #7); Heart Failure (PQI #8); Dehydration (PQI #10); Bacterial Pneumonia (PQI #11); Urinary Tract Infection (PQI #12); Uncontrolled Diabetes (PQI #14); Asthma in Younger Adults (PQI #15); and Lower-Extremity Amputation among Patients with Diabetes (PQI #16).	Measure	General	Agreement Year	Annually	4 Months after end of Measurement Period					X	X		
INTEGRITY.01	Program Integrity Plan	Plan for program integrity which shall include, at a minimum, the establishment of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse, as required in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438.	Plan		Agreement Year	Annually	May 1st, Upon Revision						X		
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	Standard template listing specific members being locked in to a pharmacy for the measurement period.	Table		Month	Monthly	1 Month after end of Measurement Period								X
LOCKIN.03	Pharmacy Lock-in Activity Summary	Standard template with aggregate data related to pharmacy lock-in enrollment and changes during the measurement period.	Table		Month	Monthly	1 Month after end of Measurement Period								X

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MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	MCO shall annually submit its managed care information system (MCIS) plans to ensure continuous operation of the MCIS. This should include the MCOs risk management plan, systems quality assurance plan, confirmation of 5010 compliance and companion guides, and confirmation of compliance with IRS publication 1075.	Plan		Agreement Year	Annually	June 1st									X
MEMCOMM.01	Member Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound member calls answered by a live voice within 30 seconds, by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period					X	X			X
MEMCOMM.03	Member Communications: Calls Abandoned	Count and percent of inbound member calls abandoned while waiting in call queue, by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period					X	X			X
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	Count and percent of inbound member telephone inquiries connected to a live person by reason for Inquiry. Reasons include A: Benefit Question Non-Rx, B: Rx-Question, C: Billing Issue, D: Finding/Changing a PCP, E: Finding a Specialist, F: Complaints About Health Plan, G: Enrollment Status, H: Material Request, I: Information/Demographic Update, J: Giveaways, K: Other, L: NEMT Inquiry	Measure		Month	Monthly	1 Month after end of Measurement Period							X		X
MEMCOMM.24	Member Communications: Calls Returned by the Next Business Day	Count and percent of member voicemail or answering service messages responded to by the next business day.	Measure		Month	Monthly	1 Month after end of Measurement Period							X		X

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MEMINCENTIVE.01	Member Incentive Table	Standard template reporting detail around member incentives including category, number of payments, and dollar value of payments for member incentive payments during the measurement period. Annually the MCO will include a statistically sound analysis of the member incentive program and identify goals and objectives for the following year.	Table		Quarter	Quarterly	2 Months after end of Measurement Period								X
MEMINCENTIVE.02	Member Incentive Plan	Annual member incentive plan including goals and objectives associated with the MCO's member incentive strategy.	Plan		Agreement Year	Annually	May 1st								X
MHACT.01	Adult CMHP Assertive Community Treatment (ACT) Service Utilization	Count and percent of eligible Community Mental Health Program (CMHP) members receiving at least one billed Assertive Community Treatment (ACT) service in each month of the measurement period.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
MHDISCHARGE.01	Follow-up Visit after Community Hospital, APRT Facility or DRF Discharge for Mental Health-Related Conditions - Within 7 Days of Discharge	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF) with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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MHDISCHARGE.02	Follow-up Visit after Community Hospital, APRT Facility or DRF Discharge for Mental Health-Related Conditions - Within 30 Days of Discharge	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF) with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 30 calendar days of discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHEDBRD.01	Emergency Department Psychiatric Boarding Table	Standard template broken out by children and adults with the number of members who awaited placement in the emergency department or medical ward for 24 hours or more. Summary totals by disposition of those members who were waiting for placement; the average length of stay while awaiting placement; and the count and percent of those awaiting placement who were previously awaited placement within the prior 30, 60 and 90 days.	Table		Month	Monthly	1 Month after end of Measurement Period								X
MHREADMIT.03	Mental Health Readmissions: Service Utilization Prior to Readmission	For Members for the measurement month who represented a readmission within 180 days, the MCO will report on the mental health and related service utilization that directly proceeded readmission in accordance with Exhibit O.	Table		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
MHREADMIT.04	Readmissions for Mental Health Conditions within 30 Days of Discharge - Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF), with a primary diagnosis for a mental health-related condition, readmitted for a mental-health related condition within 30 days of a previous discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHREADMIT.05	Readmissions for Mental Health Conditions within 180 Days of Discharge - Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF), with a primary diagnosis for a mental health-related condition, readmitted for a mental-health related condition within 180 days of a previous discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHREADMIT.06	Readmissions for Mental Health Conditions within 30 Days of Discharge - State of NH IMD Hospitals, Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from either a State of NH IMD Hospital, community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or Designated Receiving Facility (DRF) with a primary diagnosis for a mental health condition, readmitted to any of these facilities for a mental health-related condition within 30 days, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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MHREADMIT.07	Readmissions for Mental Health Conditions within 180 Days of Discharge - State of NH IMD Hospitals, Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from either a State of NH IMD Hospital, community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or Designated Receiving Facility (DRF) with a primary diagnosis for a mental health condition, readmitted to any of these facilities for a mental health-related condition within 180 days, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHSUICIDE.01	Zero Suicide Plan	Plan for incorporating the "Zero Suicide" model promoted by the National Action Alliance for Suicide Prevention (US Surgeon General) with providers and beneficiaries.	Plan		Agreement Year	Annually	May 1st								X
MHTOBACCO.01	Adult and Youth CMHP Eligible Members: Smoking Status	Count and percent of Community Mental Health Program (CMHP) Eligible Adult and Youth Members 12-17 and 18 and older who are current tobacco users.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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MLR.01	Medical Loss Ratio Report	Standard template developed by DHHS actuaries that includes all information required by 42 CFR 438.8(k), and as needed other information, including, but not limited to: <ul style="list-style-type: none"> • Total incurred claims; • Expenditures on quality improvement activities; • Expenditures related to activities compliant with the program integrity requirements; • Non-claims costs; • Premium revenue; • Taxes; • Licensing fees; • Regulatory fees; • Methodology for allocation of expenditures; • Any credibility adjustment applied; • The calculated MLR; • Any remittance owed to New Hampshire, if applicable; • A comparison of the information reported with the audited financial report; • A description of the aggregate method used to calculate total incurred claims; and • The number of Member months. [42 CFR 438.8(k)(1)(i)-(xii); 42 CFR 438.608(a)(1)-(5); 42 CFR 438.608(a)(7)-(8); 42 CFR 438.608(b); 42 CFR 438.8(l)] 	Table		Quarter	Quarterly	9 Months after end of Measurement Period						X		

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/MD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
MONTHLYOPS.01	Monthly Operations Report	This report will include details about the employment status of Key Personnel required by the MCO contract.	Table		Month	Monthly	1 Month after end of Measurement Period								X
MSQ.01	Medical Services Inquiry Letter	Standard template log of Inquiry Letters sent related to possible accident and trauma. DHHS will require a list of identified members who had a letter sent during the measurement period with a primary or secondary diagnosis code requiring an MSQ letter. For related ICD Codes please make a reference to Trauma Code Tab in this template.	Table		Month	Monthly	1 Month after end of Measurement Period						X		X
NEMT.15	NEMT Requests Delivered by Type of Medical Service	Count and percent of Non-Emergent Medical Transportation (NEMT) requests delivered, by type of medical service. Types include: A: Hospital, B: Medical Provider, C: Mental Health Provider, D: Dentist, E: Pharmacy, F: Methadone Treatment, G: Other	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
NEMT.18	Results of Scheduled NEMT Trips by Outcome	Percent of Non-Emergent Medical Transportation contracted transportation provider and wheelchair van requests scheduled for all rides requested during the measure data period by outcome of the ride. This measure includes methadone treatment rides. Exclude all Family and Friends Mileage Reimbursement Program legs from this measure. Outcomes include: A: Member cancelled or rescheduled, B: Transportation provider cancelled or rescheduled, C: Member no show, D: Transportation provider no show, E: Other reason trip wasn't made, F: Delivered and G: Unknown if trip occurred.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X

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NEMT.22	Family and Friends Program NEMT Rides	Count and percent of Non-Emergent Medical Transportation one-way rides delivered through the Family and Friends Mileage program.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
NEMT.24	Scheduled NEMT Trips Delivered On Time	Count and percent of Non-Emergent Medical Transportation (NEMT) contracted transportation provider and wheelchair van requests scheduled and delivered during the measurement period, with an outcome of delivered on time. The following exclusions apply: Exclude Methadone treatment rides. Exclude rides provided by Easter Seals.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
NEMT.25	NEMT Network Adequacy Report	TBD - This will be quarterly by mode of transportation and county. Will work through specifications with MCOs and transportation brokers.	Table		Quarter	Quarterly	TBD								X
NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Annual Filing	Standard template for the MCO to report on the adequacy of its provider network and equal access, including time and distance standards.	Table		Calendar Year	Annually	45 Calendar Days after end of Measurement Period			X	X	X			
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	MCO provider exceptions to network adequacy standards. Exceptions should include necessary detail to justify the exception and a detailed plan to address the exception.	Table		Calendar Year	Annually, Ad hoc as warranted	45 Calendar Days after end of Measurement Period			X	X	X			
NETWORK.11	Access to Care Provider Survey	Results of the MCO annual timely access to care provider survey reported in a standard template.	Table		Agreement Year	Annually	45 Calendar Days after end of Measurement Period			X	X	X			

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PDN.04	Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for child members (age 0-20 years of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
PDN.05	Private Duty Nursing: Authorized Hours for Adults Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for adult members (age 21 and older of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
PDN.07	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Year to Date detail related to members receiving private duty nursing services.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X
PDN.08	Private Duty Nursing: Network Adequacy Report	Standard template measuring the adequacy of the MCOs network for delivering private duty nursing services	Narrative Report		Quarter	Quarterly	TBD								X
PHARM_PDC.01	Proportion of Days Covered - Diabetes All Class Rate (PDC--DR)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Diabetes All Class.	Measure		Calendar Year	Annually	April 30th								X

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PHARM_PDC.02	Proportion of Days Covered - Renin Angiotensin System Antagonists (PDC-RASA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Renin Angiotensin System Antagonists.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.03	Proportion of Days Covered - Statins (PDC-STA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for statins.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.04	Proportion of Days Covered - Beta-Blockers (PDC-BB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for beta-blockers.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.05	Proportion of Days Covered - Calcium Channel Blockers (PDC-CCB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for calcium channel blockers.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.10	Proportion of Days Covered (PDC) - Adherence to Direct-Acting Oral Anticoagulants (PDC-DOAC)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to direct-acting oral anticoagulants.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.11	Proportion of Days Covered - Adherence to Long-Acting Inhaled Bronchodilator Agents in COPD Patients (PDC-COPD)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to long-acting inhaled bronchodilator agents in COPD patients.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.12	Proportion of Days Covered - Antiretroviral Medications (PDC-ARV)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for antiretroviral medications.	Measure		Calendar Year	Annually	April 30th								X

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PHARM_PDC.13	Proportion of Days Covered - Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis (PDC-MS)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused disease modifying agents used to treat Multiple Sclerosis.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.14	Adherence to Non-Infused Biologic Medications Used to Treat Rheumatoid Arthritis (PDC-RA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused biologic medications used to treat rheumatoid arthritis.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.15	Proportion of Days Covered Composite (PDC-CMP)	The composite percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year for: diabetes medications, RAS antagonists, and statins. This is a composite health plan performance measure that combines rates from the following component measures: • Component 1: Proportion of Days Covered: Diabetes All Class (PDC-DR) • Component 2: Proportion of Days Covered: Renin Angiotensin System Antagonist (PDC-RASA) • Component 3: Proportion of Days Covered: Statins (PDC-STA)	Measure		Calendar Year	Annually	April 30th								X
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Count and percent of opioid prescription fills that were prior authorized to meet the NH DHHS Morphine Equivalent Doses (MED) Prior Authorization policy in effect for the measurement period, including members with cancer or other terminal illnesses.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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PHARMQI.10	Child Psychotropic Medication Monitoring Report	Standard template of patient level and aggregated data related to children 0-18 with multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications. Totals are broken out by age categories and whether the child was involved with the Division for Children, Youth, and Families.	Table		Quarter	Quarterly	1 Month after end of Measurement Period								X
PHARMUTLMGT.02	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Count and percent of prescriptions filled for generic drugs adjusted for preferred PDL brands. (To adjust for PDL, remove brand drugs which are preferred over generics from the multi-source claims; and remove their generic counterparts from generic claims).	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
PHARMUTLMGT.03	Pharmacy Utilization Management: Generic Drug Substitution	Count and percent of prescriptions filled where generics were available, including multi-source claims.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
PHARMUTLMGT.04	Pharmacy Utilization Management: Generic Drug Utilization	Count and percent of prescriptions filled with generic drugs out of all prescriptions filled.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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PMP.01	Program Management Plan	<p>The Program Management Plan (PMP) is a document used to provide an overview of the managed care organization's (MCO) delivery of the program as it operates in New Hampshire. Details and specifications are listed below as the PMP includes key topics and associated descriptions. After the initial year the MCO should submit a certification of no change or provide a red-lined copy of the updated plan.</p> <p>Table of Contents</p> <p>I. Executive Summary</p> <p>II. Organizational structure: a. Staffing and contingency plans; b. Corporation Relationships and Structure</p> <p>III. Business Operations: a. Overview; b. Hours of operation; c. Holidays and emergency closing notification</p> <p>IV. Committees and workgroups: a. General; b. Member Advisory Board; c. Provider Advisory Board</p> <p>V. Communication: a. General; b. Vendor relationships; c. Member management; d. Providers</p> <p>VI. Systems: a. Software and information management; b. Process improvement methods; c. Project management; d. Evaluation methods</p> <p>VII. Providers: a. Management and communication; b. Relationships</p> <p>VIII. Services: a. Pharmacy; b. Behavioral Health; c. Substance Use Disorder; d. Durable medical equipment; e. Special populations; f. Transportation; g. Other Benefits</p> <p>IX. Program Operations: a. Utilization management; b. Grievance and Appeals; c. Care Management</p> <p>X. Community Engagement</p>	Plan	Agreement Year	Annually	May 1st							X
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POLYPHARM.04	Polypharmacy Monitoring: Children with 4 or More Prescriptions for 60 Consecutive Days	Count and percent of child Medicaid members with four (4) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter, by age group: A. Age 0-5 years, B. Age 6-17 years. A PDC of 80 percent or Higher indicates compliance with treatment.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
POLYPHARM.06	Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	Count and percent of adult Medicaid members with five (5) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter by age group: A. Age 18-44, B. Age 45-64 years. A PDC of 80 percent or Higher indicates compliance with treatment.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
PROVAPPEAL01	Resolution of Provider Appeals Within 30 Calendar Days	Count and percent of provider appeals resolved within 30 calendar days of the Final Provider Appeal Filing Date, for Final Provider Appeals received during the measure data period.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period						X		
PROVAPPEAL02	Provider Appeals Log	Standard template log of appeals with detail on all provider appeals including the MCO response to the appeal for provider appeals filed within the measure data period.	Table		Quarter	Quarterly	2 Months after end of Measurement Period						X		
PROVCOMM.01	Provider Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound provider calls answered by a live voice within 30 seconds by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period								X

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring	
PROVCOMM.03	Provider Communications: Calls Abandoned	Count and percent of inbound provider calls abandoned either while waiting in call queue by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.07	Provider Communications: Reasons for Telephone Inquiries	Count and percent of inbound provider telephone inquiries connected to a live person by reason for inquiry. Reasons include A: Verifying Member Eligibility, B: Billing / Payment, C: Service Authorization, D: Change of Address, Name, Contact info, etc. E: Enrollment / Credentialing, F: Complaints About Health Plan, G: Other.	Measure		Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.08	Provider Communications: Calls Returned by Next Business Day	Count and percent of provider voicemail or answering service messages returned by the next business day.	Measure		Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMPLAINT.01	Provider Complaint and Appeals Log	Standard template providing a quarterly report of all provider complaints and appeals in process during the quarter.	Table		Quarter	Quarterly	2 Months after end of Measurement Period						X			
PROVPREVENT.01	Hospital-Acquired and Provider-Preventable Condition Table	Standard template that identifies denials or reduced payment amounts for hospital-acquired conditions and provider preventable conditions. Table will include MCO claim identifier, provider, date of service, amount of denied payment or payment reduction and reason for payment denial or reduction.	Table		Annual	Annually	April 30th						X			

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
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PROVPRIV.01	Behavioral Health Written Consent Report	Narrative reporting of the results of the MCO review of a sample of case files where written consent was required by the member to share information between the behavioral health provider and the primary care provider. In these sample cases, the MCO will determine if a release of Information was included in the file. The MCO shall report instances in which consent was not given, and, if possible, the reason why.	Narrative Report		Agreement Year	Annually	4 Months after end of Measurement Period							X	X
PROVTERM.01	Provider Termination Log - including Program Integrity Elements	Standard template log of providers who have given notice, been issued notice, or have left the MCOs network during the measurement period, including the reason for termination. Number of members impacted, impact to network adequacy, and transition plan if necessary.	Table		Month	Monthly	TBD							X	X
QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Plan	Annual description of the MCO's organization-wide QAPI program structure. The plan will include the MCO's annual goals and objectives for all quality activities. The plan will include a description of the mechanisms to detect under and over utilization, assess the quality and appropriateness of care for Member with special health care needs and disparities in the quality of and access to health care (e.g. age, race, ethnicity, sex, primary language, and disability); and process for monitoring, evaluating and improving the quality of care for members receiving behavioral health services.	Plan		Calendar Year	Annually	November 30th							X	

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EXHIBIT O – Quality and Oversight Reporting Requirements

Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period and Delivery Dates			Purpose of Monitoring								
					Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring	
QAPI.02	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	The report will describe completed and ongoing quality management activities, performance trends for QAPI measures identified in the QAPI plan; and an evaluation of the overall effectiveness of the MCO's quality management program including an analysis of barriers and recommendations for improvement.	Narrative Report		Calendar Year	Annually	February 28th								X	
SDH.XX	Social Determinants of Health	Placeholder for additional measures to show MCO impact on social determinants of health (SDH)	Measure		TBD	TBD	TBD									X
SERVICEAUTH.01	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Count and percent of medical service, equipment, and supply service authorization determinations for urgent requests made within 72 hours after receipt of request for requests made during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.03	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	Count and percent of medical service, equipment, and supply service, authorization determinations for new routine requests made within 14 calendar days after receipt of request for requests made during the measure data period. Exclude authorization requests that extend beyond the 14 day period due to the following: The member requests an extension, or The MCO justifies a need for additional information and the extension is in the member's interest. Exclude requests for non-emergency transportation from this measure.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period									X

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New Hampshire Department of Health and Human Services

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SERVICEAUTH.04	Pharmacy Service Authorization Timely Determination Rate	Count and percent of pharmacy service authorization determinations made during the measurement period where the MCO notified the provider via telephone or other telecommunication device within 24 hours of receipt of the service authorization request.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Standard template summary of service authorization determinations by type and benefit decision for request received during the measure data period.	Table		Quarter	Quarterly	2 Months after end of Measurement Period				X				
SERVICEAUTH.13	Medical Service, Equipment and Supply Post-Delivery Service Authorization Timely Determination Rate	Count and percent of post-delivery authorization determinations made within 30 calendar days of receipt of routine requests, for medical services, equipment, and supply services. Exclude requests for non-emergency transportation from this measure.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.14	Service Authorization Denials for Waiver & Non-HCBC Waiver Populations	Rate of service authorizations denied during the measurement period, broken out by the fol03 : Lowing waiver groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.15	Service Authorizations: Physical, Occupational & Speech Therapy Service Authorization Denials by Waiver & Non-HCBC Waiver Populations	Rate of physical, occupational and speech therapy service authorizations denied during the measurement period, broken out by the fol03 - Lowing groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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SMI_CMS.26	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SMI by Subpopulation	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period. (CMS 1115 SMI DEMONSTRATION Metric #26)	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				
SMI_CMS.30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who are age 18 years and older, and completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication. (CMS 1115 SMI DEMONSTRATION Metric #30)	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				
SUBROGATION.01	Subrogation Report	Standard template identifying information regarding cases in which DHHS has a Subrogation lien. DHHS will inform the MCO of claims related to MCO subrogation cases that need to be included in the report.	Table		Month	Monthly	15 Calendar Days after end of Measurement Period						X		X
SUD.27	Member Access to Clinically Appropriate Services as Identified by ASAM Level of Care Determination Table	Standard template reporting members receiving ASAM SUD services as identified by initial or subsequent ASAM level of care criteria determination within 30 days of the screening. The table will include a file review of a sample of members who received an ASAM SUD service during the measurement period. Age breakouts are 0-17, 18+; exclude duals.	Table		Calendar Year	Annually	6 Months after end of Measurement Period				X				X

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SUD.39	High Opioid Prescribing Provider Monitoring Report	Narrative reporting of the MCO's identification of providers with High opioid prescribing rates and efforts to follow up with providers. The report should include the MCO's operational definition of a provider with a High opioid prescribing rate, the process for identifying and following up with providers. The report should include aggregate data about the number of providers that are identified and the follow up. Age breakouts are 0-17, 18+; exclude duals.	Narrative Report		Agreement Year	Annually	2 Months after end of Measurement Period									X
SUD.42	MCO Contacts and Contact Attempts Following ED Discharges for SUD	Count and percent of member Emergency Department discharges with an SUD principal diagnosis during the measurement period, where the MCO either successfully contacted the member within 3 business days of discharge, or attempted to contact the member at least 3 times within 3 business days of discharge, by age, 0 to 17 years and 18 years or older.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period									X
SUD.52	Member Access to SUD Services following SUD Assessment and Diagnosis	Percent of all Medicaid members with one or more SUD Treatment Services during the measurement period and a 60-day Negative Diagnosis History prior to the first treatment session who had a SUD Assessment within 3 days of the Initial SUD Treatment Service or a SUD Assessment over the course of 3 SUD treatment service sessions delivered within 30 days of the Initial Treatment Service. This assessment can be with the same provider or a different provider.	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X					X

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SUD_CMS.05	SUD Diagnosis Treated in an IMD by Subpopulation	Count and percent of Medicaid members with a claim for residential treatment for substance use disorder (SUD) in an institution for mental disease (IMD) during the reporting year, by SUD IMD subpopulation. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #5)	Measure		Agreement Year	Annually	4 Months after end of Measurement Period				X				X
SUD_CMS.25	Readmissions among Members with SUD by Subpopulation	The count and percent of acute inpatient stays among Medicaid members with substance use disorder (SUD), during the measurement period, followed by an acute readmission within 30 days, by SUD IMD subpopulation.	Measure		Agreement Year	Annually	4 Months after end of Measurement Period				X				X
SUD_CMS.32_CY	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SUD by Subpopulation	Count and percent of Medicaid members with substance use disorder (SUD) who had an ambulatory or preventive care visit during the measurement period by SUD IMD Waiver subpopulation. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #32)	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				X
SUD_CMS.36	Average Length Of Stay In An IMD For SUD by Subpopulation	Average length of stay (in days) in an Institute for Mental Disease (IMD) during the measurement year for Medicaid members who had substance use disorder (SUD) treatment, by SUD IMD subpopulation.	Measure		Agreement Year	Annually	4 Months after end of Measurement Period				X				X
SUDAUDIT.01	SUD Record Audits	All completed audit tools for each of the successive periods under review (PUR).	Table		6 Months	Semi-Annually	January 15th and July 15th								X
SUDAUDIT.02	SUD Record Audit Provider Level Summaries	Standard template that captures a summary of provider level findings from average aggregated scores	Table		6 Months	Semi-Annually	January 31st and July 31st								X

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SUDAUDIT.03	SUD Record Audits – Opioid Treatment Providers	Case level data from the MCOs audit of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).	Table		TBD	TBD	TBD									X
SUDAUDIT.04	SUD Record Audit Opioid Treatment Providers Provider Level Summaries	Standard template that captures a summary of provider level findings from average aggregated scores for the MCOs audit of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).	Table		TBD	TBD	TBD									X
TIMELYCRED.01	Timely Provider Credentialing - PCPs	The percent of clean and complete provider (PCP) applications for which the MCO or subcontractor credentials the PCP and the provider is sent notice of enrollment within 30 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period									X

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TIMELYCRED.02	Timely Provider Credentialing - Specialty Providers	The percent of clean and complete specialty provider applications for which the MCO or credentials the specialty provider and the provider is sent notice of enrollment within 45 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure. Specialty providers include Durable Medical Equipment (DME) and Optometry providers.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X
TOBACCO.01	Annual Report of MCO Tobacco Cessation Program Offerings, Operations, and Utilization	The report captures information about MCO Tobacco Cessation offerings, operations and utilization on an annual basis. For each annual submission, submit an updated clean report and a redline version of the updated report.	Narrative Report		Agreement Year	Annually	4 Months After the End of the Measurement Period								X
TOBACCO.04	Tobacco Cessation Activity Report	Report reflecting the volume of members utilizing different tobacco cessation supports such as counseling, medication, and messaging.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X
TOBACCO.XX	Tobacco Use and Cessation	Placeholder for additional measures to show MCO impact on tobacco use and cessation.	Measure		TBD	TBD	TBD								X
TPLCOB.01	Coordination of Benefits: Costs Avoided Summary Report	Standard template reporting total charge and potential paid amount for claims denied due to other benefit coverage by insurance type for the measure data period.	Table		Quarter	Quarterly	45 Calendar Days after end of Measurement Period								X
TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	Standard template log of COB medical benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans, and workers compensation.	Table		Quarter	Quarterly	45 Calendar Days after end of Measurement Period								X

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TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Standard template log of COB pharmacy benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans.	Table		Quarter	Quarterly	45 Calendar Days after end of Measurement Period								X
UMSUMMARY.03	Medical Management Committee	MCO shall provide copies of the minutes from each of the MCO Medical Utilization Management committee (or the MCO's otherwise named committee responsible for medical utilization management) meetings.	Narrative Report		Agreement Year	Annually	2 Months after end of Measurement Period						X		X

State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that AMERIHEALTH CARITAS NEW HAMPSHIRE, INC. is a New Hampshire Profit Corporation registered to transact business in New Hampshire on January 07, 2019. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: 810354

Certificate Number: 0006231897



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 16th day of May A.D. 2023.

A handwritten signature in black ink, appearing to read "D. Scanlan", is written over a circular embossed seal.

David M. Scanlan
Secretary of State

CERTIFICATE OF AUTHORITY

I, Robert E. Tootle, hereby certify that:

1. I am the duly elected Secretary of AmeriHealth Caritas New Hampshire, Inc.;
2. The following is a true copy of a resolution duly adopted at a meeting of the Board of Directors, duly held on November 30, 2022:

RESOLVED, that William Keena, Market President, is duly authorized on behalf of AmeriHealth Caritas New Hampshire, Inc. to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority remains valid until repealed by the Board of Directors. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

DocuSigned by:
Robert E. Tootle
52B135D7BFF74C8...

Robert E. Tootle
Secretary

26-May-2023

Date



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
11/23/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh USA Inc. 1717 Arch Street Philadelphia, PA 19103-2797 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307 CN102240002-GAU-CAS-22-23 INSURED AMERIHEALTH CARITAS NEW HAMPSHIRE, INC. 25 SUNDIAL AVENUE, SUITE 130W MANCHESTER, NH 03103	CONTACT NAME: PHONE (A/C, No, Ext): _____ FAX (A/C, No): _____ E-MAIL ADDRESS: _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center;">INSURER(S) AFFORDING COVERAGE</th> <th style="text-align: center;">NAIC #</th> </tr> <tr> <td colspan="2">INSURER A : N/A</td> <td style="text-align: center;">N/A</td> </tr> <tr> <td colspan="2">INSURER B : American Guarantee & Liability Ins Co</td> <td style="text-align: center;">26247</td> </tr> <tr> <td colspan="2">INSURER C :</td> <td></td> </tr> <tr> <td colspan="2">INSURER D :</td> <td></td> </tr> <tr> <td colspan="2">INSURER E :</td> <td></td> </tr> <tr> <td colspan="2">INSURER F :</td> <td></td> </tr> </table>	INSURER(S) AFFORDING COVERAGE		NAIC #	INSURER A : N/A		N/A	INSURER B : American Guarantee & Liability Ins Co		26247	INSURER C :			INSURER D :			INSURER E :			INSURER F :		
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INSURER F :																						

COVERAGES CERTIFICATE NUMBER: CLE-006880345-02 REVISION NUMBER: 2

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADOL	SUBR INSD	WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
B	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY				CPO440395203	11/30/2022	11/30/2023	EACH OCCURRENCE	\$ 1,000,000	
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR								DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 1,000,000
	<input checked="" type="checkbox"/> GL 2M Agg.Per Loc. subj.to max <input type="checkbox"/> 20M Gen. Agg.-All Loc.Combined								MED EXP (Any one person)	\$ 10,000
	GENL AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER: _____							PERSONAL & ADV INJURY	\$ 1,000,000	
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY <input type="checkbox"/>							GENERAL AGGREGATE	\$ 2,000,000	
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$							PRODUCTS - COMP/OP AGG	\$ 2,000,000	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below				Y/N				N/A	
								COMBINED SINGLE LIMIT (Ea accident)	\$	
								BODILY INJURY (Per person)	\$	
								BODILY INJURY (Per accident)	\$	
								PROPERTY DAMAGE (Per accident)	\$	
									\$	
								EACH OCCURRENCE	\$	
								AGGREGATE	\$	
									\$	
								PER STATUTE	OTHER	
								E.L. EACH ACCIDENT	\$	
								E.L. DISEASE - EA EMPLOYEE	\$	
								E.L. DISEASE - POLICY LIMIT	\$	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER STATE OF NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES 129 PLEASANT STREET CONCORD, NH 03301-3857	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE <p style="text-align: right; font-style: italic;">Marsh USA Inc.</p>
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ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

01/05/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Conner Strong & Buckelew PO Box 99106 Camden, NJ 08101	CONTACT NAME: Jenna Jachimiak PHONE (A/C, No, Ext): 856 446-9285 FAX (A/C, No): E-MAIL ADDRESS: jjachimiak@connerstrong.com
	INSURER(S) AFFORDING COVERAGE
	INSURER A: Zurich American Insurance Company INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:
INSURED AmeriHealth Caritas New Hampshire, Inc. 25 Sundial Avenue, Suite 130W Manchester, NH 03103	NAIC # 16535

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:					EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	WC050294805	01/01/2023	01/01/2024	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$1,000,000 E.L. DISEASE - EA EMPLOYEE \$1,000,000 E.L. DISEASE - POLICY LIMIT \$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER State of New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301-3857	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE <i>W. Michael Ferguson</i>
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**THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT**

License No: 89279754

**Presents that Amerihealth Caritas New Hampshire, Inc.
is hereby authorized to transact HMO lines of Insurance
in accordance with State Statute RSA 420-B
Exclusions: 8. Restricted to Medicaid Managed Care.**

**Effective Date: 06/15/2023
Expiration Date: 06/14/2024**



Christopher R. Nicolopoulos

**Christopher R. Nicolopoulos, Esq.
Commissioner of Insurance**

DEC 15 '22 PM 12:00 RCVD

ARC

13A



Lori A. Shilbette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAID SERVICES

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

December 12, 2022

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into Retroactive amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$245,113,188 from \$4,473,715,686 to \$4,718,828,874 (for the period since contract inception September 2019), with no change to the completion date of August 31, 2024, and effective retroactive to July 1, 2022, upon Governor and Council approval. All terms and conditions of the contract and prior amendment not inconsistent with this Amendment remain in full force and effect. The federal fund share comprises 81% of the price limitation increase, the other non-federal fund share is 12%, and the general fund is 7% from the previous Amendment.

Funding sources are as follows:

	Federal	Other / Agency Income	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	69.34%	1.07%	29.59%
Standard Medicaid Population (Medicaid Care Management)	53.6%	22.4%	24.00%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of FMAP for the Children's Health Insurance Program (CHIP) population remains available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019; (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020 (Item #8), January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), as

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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amended on December 08, 2021 (Item #6-1), and as amended on June 15, 2022 (Item # Tabled Item 20A).

Funds are available in the accounts outlined in the attached fiscal details and are available in the State Fiscal Year (SFY) 2023, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

The Centers for Medicare & Medicaid Services (CMS) requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2023.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request is Retroactive because it covers the rating period of July 1, 2022 through June 30, 2023. The methodology used to develop the previous Amendment #8 SFY 2023 capitation rates is largely consistent with the capitation rate methodology in this Amendment #9.

The federal Public Health Emergency (PHE) continues to have an impact on program costs. In order for states to receive the 6.2% enhanced Federal Medical Assistance Percentage (FMAP) the Families First Coronavirus Response Act requires continuous enrollment by states for individuals who were or became Medicaid eligible since March 13, 2020 through at least April 2023. The PHE end date was not noticed on November 12, 2022, so an end of the PHE in January is off the table unless there is Congressional intervention. The PHE, therefore, is likely to run through April 2023.

As of the beginning of December, the NH Medicaid program has 100,481 individuals protected from disenrollment due to continuous enrollment, out of an enrollment of over 246,616 as of December 5, 2022. Absent the continuous enrollment requirement, as of November 30, 2022, more than 29,000 people are known to be ineligible based on completed redeterminations of eligibility (or nearly 12% of current enrollees). Another nearly 35,000 individuals are potentially ineligible since they have not yet completed an annual redetermination of eligibility, which is not required during the PHE. Over 36,000 are both overdue in completing a redetermination and potentially ineligible based on yet to be verified information available to DHHS. Any material disenrollment is unlikely in this rate year, and is likely to begin no earlier than May 1, 2023.

While the State continues to receive 6.2% enhanced FMAP on certain Medicaid expenditures, the enhanced federal payment excludes the NH Granite Advantage Health Care Program at 90% FMAP already, and where enrollment growth for NH has been the greatest both on a percentage (81.6%), and an absolute enrollment growth basis (41,924) since mid-March 2020. For Amendment #9 relative to the rates:

1. An end of year retroactive non-budget neutral rate adjustment based on actual enrollment was not actuarially made by the State's actuary, as the acuity impact is very likely de minimis.


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2. Rates are calibrated to reflect a PHE end date in April 2023. Once ended, beneficiaries whose eligibility determination shows they no longer meet eligibility criteria will be disenrolled from Medicaid as Federal guidance permits. In order to minimize gaps in healthcare coverage, DHHS, the MCOs, providers and other stakeholders are working to engage beneficiaries. The disenrollment activity is expected to reduce program membership and related costs over the course of the unwind enrollment period.
3. The rates per person aggregate modestly decrease, while the price limitation has increased to reflect the much higher than anticipated enrollment related to the PHE continuing. Generally, states anticipate that when the PHE disenrollment commences, the premiums will rise per person, but the number of people enrolled will decline. Over time, this will lead to lower contract price limitations due to declining enrollment. The enrollment decline and related cost-savings will be realized from exiting individuals who generally have lower illness burden and lower healthcare costs.
4. Tables 1A and 1B in the Appendix depict monthly capitation rates, by major population eligibility groups, and the percent change from the prior Amendment. The rates in Table 1A exclude directed payments which are fixed costs, while Table 1B includes the fixed costs. The price limitation change is calculated off of the Table 1B capitation rates. The rates in the aggregate decline favorably by 0.7% for standard and 2.4% for the GAHCP. Taken together, standard and GAHCP capitation rates decline favorably by 1.5%.
5. Table 2 lays out the capitation rate change components. The top half of the chart shows program changes that increased costs unfavorably by \$7.15 million. The two largest changes are related to legislation enacted into law in the recent legislative session to improve birthing services and ambulance rates. The third largest captures professional billing for Medicaid at state-owned psychiatric facilities. The bottom half of the chart reflects the actuarial rating adjustments that lowered costs by \$27.56 million. The three largest changes are an acuity adjustment, fixed costs that do not increase with the increase in enrollment, and staffed bed constraints in psychiatric capacity.

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,


Lori A. Shibinette
Commissioner

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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APPENDIX

Table 1A
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Excluding Directed Payments
April PHE End Date

Population	Amendment #8	Amendment #9	Rate Change
Standard Medicaid			
Base Population	\$349.04	\$348.81	-0.1%
CHIP	211.15	213.50	1.1%
Behavioral Health Population	1,459.07	1,431.84	-1.9%
Total Standard Medicaid	\$406.64	\$404.89	-0.4%
Granite Advantage Health Care Program			
Medically Frail	\$1,097.65	\$1,074.95	-2.1%
Non-Medically Frail	419.51	414.34	-1.2%
Behavioral Health Population	2,054.51	2,015.13	-1.9%
Total GAHCP	\$564.78	\$558.60	-1.5%
Grand Total	\$487.51	\$483.25	-0.9%

Table 1B
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Including Directed Payments
April PHE End Date

Population	Amendment #8	Amendment #9	Rate Change
Standard Medicaid			
Base Population	\$361.13	\$360.19	-0.3%
CHIP	216.81	218.32	0.8%
Behavioral Health Population	1,514.89	1,483.27	-2.1%
Total Standard Medicaid	\$420.82	\$418.10	-0.6%
Granite Advantage Health Care Program			
Medically Frail	\$1,150.89	\$1,113.50	-3.3%
Non-Medically Frail	432.57	423.65	-2.1%
Behavioral Health Population	2,097.00	2,050.34	-2.2%
Total GAHCP	\$563.49	\$570.08	-2.3%
Grand Total	\$483.43	\$476.60	-1.4%

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Table 2
New Hampshire Department of Health and Human Services
SFY 2023 MCO Capitalization Rate Change by Component
Based on Projected SFY 2023 Enrollment by Rate Cell
April 2023 Rate Cell Scenario

Rate Component	Standard Method		GAMP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Covered Services and Fee Schedule Changes						
Remote patient monitoring services ¹	0.0%	44,502	0.0%	14,051	0.0%	58,553
Birthdays services reimbursement ²	0.4%	2,704,603	0.0%	268,607	0.2%	2,973,210
Advanced lab tests ³	0.0%	181,054	0.0%	74,476	0.0%	255,530
Ambulance emergency medical transportation rates ⁴	0.1%	1,028,020	0.1%	973,491	0.1%	2,001,511
Friends and family NEMT rates ⁴	0.0%	305,170	0.1%	483,203	0.1%	788,373
Chair car transportation rates ⁴	0.0%	178,968	0.0%	111,769	0.0%	290,737
State-owned hospital professional services ⁴	-0.1%	624,648	0.0%	182,776	0.1%	807,424
SUD residential services ⁴	0.0%	72,426	0.1%	646,173	0.0%	618,600
Total program changes	0.7%	5,159,692	0.4%	2,632,525	0.6%	7,792,217
Other changes relative to Amendment #8 SFY 2023 rating assumptions						
SFY 2023 acuity adjustment compared to Amendment #8 acuity assumption ¹	-0.2%	(\$1,270,728)	-1.3%	(\$8,519,200)	-0.7%	(\$9,789,928)
October 2022 DRG weights ²	0.0%	158,231	0.0%	193,003	0.0%	351,234
State-owned hospital planning constraints ³	-0.4%	(\$272,851)	-0.2%	(\$1,087,774)	-0.3%	(\$4,360,625)
Applied behavioral analysis service brands ⁴	-0.1%	(\$12,628)	0.0%	3,762	-0.1%	(\$9,866)
Impact of enrollment increase on the P&M value of fixed-dollar directed payments ⁴	-0.5%	(\$973,112)	-1.1%	(\$346,323)	-0.6%	(\$1,319,435)
Other ⁴	-0.1%	(\$15,676)	-0.1%	(\$57,612)	-0.1%	(\$73,288)
Total other changes	-1.3%	(\$986,664)	-2.7%	(\$17,614,143)	-2.0%	(\$27,600,807)
Total rate change for Amendment #9 relative to Amendment #8 rates	-0.6%	(\$4,846,972)	-2.3%	(\$14,981,618)	-1.4%	(\$19,828,591)

- 1 The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.
- 2 The other change component can include items, such as changes in fee-for-service fees from SFY 2022 to SFY 2023, base data updates, refreshed financial items from MCOs, and modifications to program change effective dates among other things.
- 3 This change is retroactive to July 1, 2022. The fiscal impact represents a twelve-month period.
- 4 This change is effective after July 1, 2022. The fiscal impact represents less than a twelve-month period.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Medicaid Care Management Services Contract Amendment #9 Fiscal Details

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HMS: DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,408		\$533,510,408
SFY 2022	101-500729	Medical Payments to Providers	\$575,768,481		\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	\$446,902,230	\$177,489,903	\$624,392,133
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$1,864,849,263	\$177,489,903	\$2,042,339,166

05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HMS: DIVISION MEDICAID SERVICES, OFC OF MEDICAID SERVICES CHILD HEALTH INSURANCE PROGRAM

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$102,351,504		\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	\$102,152,951	\$16,223,840	\$118,376,791
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$323,378,814	\$16,223,840	\$339,602,654

05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HMS: DIVISION OF MEDICAID SERVICES, OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$618,433,737		\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	\$578,866,727	\$51,399,445	\$630,266,172
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$2,285,487,609	\$51,399,445	\$2,336,887,054
Total Funds			\$4,473,716,886	\$245,113,188	\$4,718,828,874

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

Lori A. Shiblette
Commissioner

Henry D. Lipman
Director

129 PLEASANT STREET, CONCORD, NH 03301
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Fax: 603-271-8431 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

May 23, 2022

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$1,127,921,908 from \$3,345,793,778 to \$4,473,715,686, with no change to the completion date of August 31, 2024, and effective July 1, 2022, upon Governor and Council approval. All terms and conditions of the contract and prior amendment not inconsistent with this Amendment remain in full force and effect.

Funding sources are as follows:

	Federal	Other / Agency Income	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	66.1%	1.6%	32.3%
Standard Medicaid Population (Medicaid Care Management)	52.7%	22.2%	25.1%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of FMAP for the Children's Health Insurance Program (CHIP) population remains available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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(Item #6), January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), and as amended on December 08, 2021 (Item #6-1).

Funds are available in the accounts outlined in the attached fiscal details and are anticipated to be available in the State Fiscal Year (SFY) 2023, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

CMS requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2023.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request covers the rating period of July 1, 2022, through June 30, 2023. There are three key purposes for this amendment. They are:

1. Amendment #8 Target Medical Loss Ratio, Administrative Allowance, and Rates

- The Department's actuary projects an overall MCO medical loss ratio (MLR) for at-risk services of 90.8% for the Standard Medicaid population and 90.1% for the GAHCP population in SFY 2023, which includes the rate development highlights below.
 - An overall 7.7% administrative cost allowance for the Standard Medicaid population, and 8.4% for the GAHCP population; representing a reduction in percentages from SFY 2022 as funding remains consistent with the current contract period.
 - A 1.5% risk margin applied as a percentage of revenue prior to the directed payments and the 2.0% premium tax allowance.
 - The composite capitation rates shown are based on DHHS projections of MCO enrollment for SFY 2023, which include considerations for the unwind process following the end of the Public Health Emergency (PHE) with enrollment returning to near pre-PHE levels by March 2023. It is likely in the future Amendment #9 that enrollment will need to be recalibrated if the federal government continues to extend the federal PHE.
- Included in the Appendix to this letter:
 - Table 1A shows the rate impact excluding directed payments, as well as with and without the SMI/SED (Severely Mentally Ill/Severely Emotionally Disturbed) 1115 waiver amendment to the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) Demonstration at 3.8% to the total composite rate.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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- o Table 1B takes into account directed payments and reflects a change of 1.8%.
- o Table 2 shows the component changes leading to the 1.8% increase in composite rate.
- o The price limitation is \$168,631,814 less than SFY 2022 (prior to any legislation enacted after the contract date).

2. Risk Mitigation Structure

- Retrospective acuity adjustment due to the uncertainty surrounding the continuous membership unwind process following the end of the PHE as authorized by the Center for Medicare and Medicaid Services (CMS) Division of Managed Care Policy on May 11, 2022. The purpose is to appropriately account for this uncertainty; DHHS will implement a non-budget neutral retroactive acuity adjustment to include a preliminary acuity assumption that will be updated following the contract year to reflect the actual population covered throughout SFY 2023; the preliminary risk adjustment for the expected enrollment composition changes the amount to an \$11.9 million increase.

- Minimum and maximum medical loss ratio (MLR) remains in effect for SFY 2023, to protect against a windfall or underfunding of services within the Program.

The minimum MLR is set on a program-wide basis for each major population, such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs, the minimum MLR will be 88.3% for the Standard Medicaid population and 87.6% for the GAHCP population.

The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that MCOs will have a maximum loss of 2.0%. Based on the target MLRs the maximum MLR will be 94.3% for the Standard Medicaid population and 93.6% for the GAHCP population.

The final minimum and maximum MLRs for Standard Medicaid and GAHCP will be updated for the final retroactive acuity factor and any other changes implemented covering the amendment period starting January 2023.

- Other existing adjustment factors risk-neutral to the State continue in the Program. The risk mitigation structure is consistent with the structure included in the SFY 2022 capitation rates with the one modification to include a retrospective acuity adjustment that addresses uncertainty caused by the end of the PHE.
- On page 9 of the 2022-2023 Medicaid Managed Care Rate Development Guide, "CMS recommends all states implement a 2-sided risk mitigation strategy for rating periods impacted by the Public Health Emergency." Due to population and cost uncertainty related to the ongoing PHE and the anticipated enrollment redetermination process.

3. Other Program Rate Adjustments

- SFY 2023 component changes in Table 2 (see Appendix) are expressed relative to the same components in the SFY 2022 rates.
- Incorporation of the Institution for Mental Disease (IMD) SMI/SED Waiver effective July 1, 2022 (pending CMS approval), DHHS will implement its SMI/SED (Severely

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Mentally Ill/Severely Emotionally Disturbed) 1115 waiver amendment to the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) Demonstration.

The waiver amendment allows DHHS to claim additional federal matching funds for Medicaid enrollees aged 21 through 64 years treated in an Institution for Mental Disease (IMD), including at New Hampshire Hospital and Hampstead Hospital for lengths-of-stay greater than 15 days and no more than 60 days for an individual (the average length-of-stay for all beneficiaries cannot exceed 30 days).

- Medical trend adjustment since the start of the COVID-19 pandemic and PHE, service utilization levels in the Medicaid program have lagged behind CY 2019 utilization by rate cell and on an aggregate basis; therefore, capitation rates assume SFY 2023 utilization levels will be consistent with CY 2019. As such, utilization trends from CY 2019 to SFY 2023 remain constant with the exception of Applied Behavioral Analysis (ABA) services with an annual trend rate from CY 2019 to SFY 2023 at 21.7%. ABA services are an evidence-based consultation, assessment and treatment option for children with autism spectrum disorder or other developmental conditions that can improve social, communication, and learning skills.
- Preliminary acuity adjustment is an increase because it reduces costs by a lower amount in SFY 2023 than SFY 2022 largely due to the current estimate of enrollment timing and trajectory during the PHE unwind.
- Pharmacy trend and savings. The pharmacy trend assumptions in Table 2 are based on a combination of historical New Hampshire Medicaid data analysis, Milliman's research on utilization and cost trends, and publicly available trend reports and forecasts.

Pharmacy savings were shown in the preferred drug list (PDL) analysis. The pharmacy savings analysis undertaken for this amendment included savings related to adjustments for prescribing efficiency opportunities for several drug classes related to asthma, HIV, and autoimmune disorders. The savings amounted to \$907,740 for the rating period, though the savings were less than SFY 2022 resulting in a cost increase for this line item. Lastly, the J-code class of injectable drugs reflects market trends.

- Opioid addiction treatment trend adjustment to the base experience data underlying the MCM capitation rates to account for the estimated change in both prevalence and cost of treatment for the opioid addiction treatment population. Based on the Actuary's review of SFY 2015 through October 2021 MCO encounter data, they determined the proportion of opioid addiction population started to decrease for several rate cells. This decrease in the proportion of opioid addiction population results in adjustments of less than 1.00 for several rate cells.
- Directed payment adjustment to remove the completed SFY 2022 HCBS (Home and Community Based Service) payments related to time limited American Rescue Plan enhanced FMAP for HCBS.
- Funding for 14 additional Community Residential Beds coming into service. Expanded services to fund an additional 14-bed community residential services at roughly \$958,000 (including administration, premium tax and margin).

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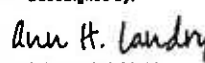
- Reimbursement adjustments to reflect recent or expected changes in the Medicaid Fee-for-Service (FFS) provider fee schedule based on Medicare Fee Schedule changes including:
 - Current Ambulatory Surgical Center fee schedule effective January 1, 2022;
 - Professional and other services fee schedules effective January 1, 2022; and
 - J-code repricing effective July 1, 2022, and other routine fee schedule updates.

- Other adjustments included in the rate change driver table (Table 2) for the SFY 2023 rates:
 - Base data update (e.g., lower/higher incurred but not reported (IBNR) expenses than previously estimated);
 - Enrollment projection impact on fixed dollar items (e.g., Community Mental Health Agreement funding);
 - Changes in FFS fee schedule from SFY 2022 to SFY 2023;
 - Refreshed financial data items from the MCOs (e.g., provider incentive payments);
 - Changes in enrollment information (e.g., retroactive change in rate cell assignment);
 - Changes in stop loss attachment point for high-cost member claims; and
 - Changes in program effective dates (e.g., Behavioral Health Crisis Treatment Centers (BHCTC), genetic testing)

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session. In the event the contract is not approved before June 30, 2022, the available federally permitted retroactive risk adjustment mitigation to account for the uncertainty of the PHE unwind will not be available to New Hampshire.

Respectfully submitted,

DocuSigned by:

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Lori A. Shibinette
Commissioner

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and the Honorable Council
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APPENDIX

Table 1A New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2023 Capitation Rate Change Based on Projected SFY 2023 Enrollment by Rate Cell Excluding Directed Payments					
Population	SFY 2022	SFY 2023		Percentage Change	
		Excluding Impact of SMI/SED 1115 Waiver Amendment	Total	Excluding Impact of SMI/SED 1115 Waiver Amendment	Total
Standard Medicaid					
Base Population	\$328.56	\$344.83	\$346.28	5.0%	5.4%
CHIP	192.68	213.67	214.07	10.9%	11.1%
Behavioral Health Population	1,381.53	1,408.40	1,461.70	1.9%	5.8%
Total Standard Medicaid	\$384.19	\$401.87	\$406.85	4.6%	5.9%
Granite Advantage Health Care Program					
Medically Frail	\$1,091.37	\$1,093.39	\$1,097.65	0.2%	0.6%
Non-Medically Frail	418.97	418.07	419.51	-0.2%	0.1%
Behavioral Health Population	1,933.60	1,951.04	2,033.26	0.9%	5.2%
Total GAHCP	\$563.17	\$563.42	\$568.33	0.0%	0.9%
Grand Total	\$441.88	\$453.94	\$458.90	2.7%	3.8%

Table 1B New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2023 Capitation Rate Change Based on Projected SFY 2023 Enrollment by Rate Cell Including Directed Payments					
Population	SFY 2022	SFY 2023		Percentage Change	
		Excluding Impact of SMI/SED 1115 Waiver Amendment	Total	Excluding Impact of SMI/SED 1115 Waiver Amendment	Total
Standard Medicaid					
Base Population	\$352.95	\$356.71	\$358.17	1.1%	1.5%
CHIP	198.39	219.27	219.67	10.5%	10.7%
Behavioral Health Population	1,470.78	1,464.33	1,517.68	-0.4%	3.2%
Total Standard Medicaid	\$410.57	\$416.00	\$420.88	1.3%	2.5%
Granite Advantage Health Care Program					
Medically Frail	\$1,144.47	\$1,146.77	\$1,150.99	0.2%	0.6%
Non-Medically Frail	432.79	431.13	432.57	-0.4%	-0.1%
Behavioral Health Population	2,001.29	1,992.81	2,075.12	-0.4%	3.7%
Total GAHCP	\$583.63	\$582.21	\$587.11	-0.2%	0.6%
Grand Total	\$466.35	\$469.57	\$474.53	0.7%	1.8%

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Table 2 New Hampshire Department of Health and Human Services SFY 2023 MCM Capitation Rate Change by Component ¹ Based on Projected SFY 2023 Enrollment by Rate Cell						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Inclusion of IMD admissions of less than 60 days for age 21-64 population as a covered Medicaid service through SMI/SED 1115 waiver amendment to the SUD-TRA 1115 demonstration						
Newly covered New Hampshire Hospital (NHH) admissions repriced at NHH minimum fee schedule	1.1%	\$7,703,888	0.8%	\$3,755,578	1.0%	\$11,459,465
Reversal of IMD exclusion for other impacted services	0.1%	\$672,069	0.0%	\$163,043	0.1%	\$835,112
Total impact of SMI/SED 1115 waiver amendment	1.2%	\$8,375,957	0.8%	\$3,918,620	1.1%	\$12,294,578
Other program changes						
New Hampshire and Hampstead Hospitals – repricing to minimum fee schedule for services historically covered by MCM program	0.5%	\$3,450,893	0.1%	\$365,521	0.3%	\$3,818,514
Community residential services – additional beds	0.1%	745,993	0.0%	121,129	0.1%	867,123
Preliminary SFY 2023 acuity adjustment compared to SFY 2022 acuity assumption	0.7%	4,789,045	1.5%	7,211,855	1.0%	11,981,000
Total other program changes	1.3%	\$8,966,032	1.6%	\$7,698,605	1.4%	\$16,664,636
Other changes relative to SFY 2022 rating assumptions						
Non-pharmacy utilization trends	-1.1%	(7,844,706)	-1.1%	(5,248,839)	-1.1%	(13,093,545)
Opioid addiction treatment trend adjustment	-0.5%	(3,148,990)	-0.8%	(3,909,040)	-0.6%	(7,058,031)
Inpatient and outpatient hospital unit cost trends	0.5%	3,184,479	0.6%	2,980,746	0.5%	6,165,225
Applied behavioral analysis service trends	1.1%	7,450,186	0.0%	5,939	0.6%	7,456,105
Pharmacy trends	2.4%	16,751,556	0.3%	1,296,337	1.6%	18,047,893
Preferred drug list (PDL) adjustment	-0.1%	(1,000,190)	-0.9%	(4,036,173)	-0.4%	(5,036,363)
Pharmacy savings initiatives	0.0%	121,825	0.1%	406,868	0.0%	528,693
J Code fee schedule changes	0.1%	1,033,584	0.2%	991,855	0.2%	2,025,439
Boston Children's Hospital risk pool funding level	0.3%	1,955,549	0.0%	34,726	0.2%	1,990,275
Other	0.3%	2,227,495	0.0%	(21,256)	-0.2%	2,206,240
Total Other Changes	3.0%	\$20,732,768	-1.6%	(\$7,498,837)	1.1%	\$13,233,931
Total rate change for SFY 2023 relative to SFY 2022 rates (prior to directed payment changes)						
	5.5%	\$38,074,756	0.9%	\$4,118,388	3.6%	\$42,193,145
Directed payment changes						
Removal of HCBS directed payment	-3.3%	(23,012,503)	-0.7%	(3,377,214)	-2.3%	(26,389,717)
Impact of enrollment decrease on the PMPM value of fixed-dollar directed payments ²	0.4%	2,431,500	0.4%	2,047,234	0.4%	4,478,733
Total directed payment changes	-3.0%	(\$20,581,003)	-0.3%	(\$1,328,981)	-1.9%	(\$21,910,984)
Total rate change for SFY 2023 relative to SFY 2022 rates (after directed payment changes)						
	2.5%	\$17,493,753	0.6%	\$2,788,408	1.8%	\$20,282,161

¹ The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.
² The SFY 2023 directed payments remain at \$33 million for critical access hospitals and \$5 million for CMHCs. Lower projected enrollment for SFY 2023 compared to SFY 2022 results in higher PMPM amounts to fund the directed payments.

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**Medicaid Care Management Services Contract
Amendment #8 Fiscal Details**

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND					
State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	\$575,768,481		\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	\$0	\$446,902,230	\$446,902,230
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,417,947,033	\$446,902,230	\$1,864,849,263
05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION MEDICAID SERVICES, OFC OF MEDICAID SERVICES CHILD HEALTH INSURANCE PROGRAM					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$102,351,504		\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	\$0	\$102,152,951	\$102,152,951
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$221,225,863	\$102,152,951	\$323,378,814
05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$618,433,737		\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	\$0	\$578,866,727	\$578,866,727
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,706,620,882	\$578,866,727	\$2,285,487,609
		Total Funds	\$3,345,793,778	\$1,127,921,908	\$4,473,715,686



Lori A. Shibinette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

129 PLEASANT STREET, CONCORD, NH 03301
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December 2, 2021

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into **Retroactive** amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$107,893,151 from \$3,237,900,627 to \$3,345,793,778, with no change to the completion date of August 31, 2024, and effective retroactive to July 1, 2021 upon Governor and Council approval. Funding sources are as follows:

	Federal	Other	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	67.40%	0%	32.60%
Standard Medicaid Population (Medicaid Care Management)	53.57%	0%	46.43%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of FMAP for the Children's Health Insurance Program (CHIP) population remains available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. Additionally, the American Rescue Plan of 2021 potentially provides an additional 10% FMAP for a one year period (April 1, 2021-March 31, 2022) for certain home and community based services (HCBS) covered in this contract based on an approved Centers for Medicare and Medicaid Services (CMS) HCBS spending plan. The Department will request Fiscal Committee approval to accept and expend additional amounts for January 2022 forward. The adjusted price limitation, given the enhanced FMAP and provisions in HB 2, should be sufficient to stay within the budget for SFY 2022. Legislation under consideration by Congress could impact the CHIP and Standard Federal share amounts.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020

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(Item #6), January 22, 2021 (Item #9), and as amended on June 30, 2021 (Item # Tabled Item 8A).

Funds are available in the accounts outlined in the attached fiscal details and are anticipated to be available in the State Fiscal Year (SFY)2022, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

CMS requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2022.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request is **Retroactive** because it covers the rating period of July 1, 2021, through June 30, 2022. There are three key purposes for this amendment:

- First, is to incorporate the impact of acuity (i.e., the measure of beneficiaries' collective medical conditions) due to an increase in new enrollment as the result of an extended federal public health emergency and extended continuous enrollment. Generally, there has been a decrease in acuity that moderates claims expense costs compared to the rates approved under Amendment #6;
- Second, is to incorporate the increased costs of legislative changes from both federal legislation and state actions in the most recent legislative session; and
- Third, is to incorporate fee schedule updates, and an adjustment for pharmacy management.

Further Explanation

Amendment #7 adjusts the SFY 2022 capitation rates. The Department's contracted actuary, Milliman, projects an overall MCO medical loss ratio (MLR) for at-risk services of 90.7% for the Standard Medicaid population and 90.0% for the GAHCP population in SFY 2022, which includes the rate development highlights below.

Milliman used the following methodology to develop the New Hampshire MCM program capitation rates:

1. Rate methodology

The methodology used to develop the Amendment #7 SFY 2022 MCM capitation rates is consistent with the Amendment #6 capitation rate methodology.

2. Changes in enrollment

CMS instructed the Department to review emerging enrollment and Public Health Emergency (PHE) conditions for Amendment #7. The updated capitation rates are based

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and the Honorable Council
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on the Department's updated projections of MCO enrollment for SFY 2022 which include continued enrollment growth through SFY 2022.

3. Acuity adjustment

For the Amendment #7 SFY 2022 MCM capitation rates, Milliman updated the acuity adjustment factors taking into account the nature of the new enrollment compared to historical enrolled individuals.

4. Federal and State Legislative actions

a. Home and community based services (HCBS) enhanced federal funding

HCBS directed payments available under Section 9817 of the American Rescue Plan Act (ARPA) provide enhanced federal funding for state Medicaid spending on home and community based services. Beginning April 1, 2021, through March 31, 2022, states are eligible to receive a ten (10) percentage point increase in their FMAP for specified HCBS services. In order to claim the enhanced FMAP eligible under the MCO contracts, the Department is proposing to implement a new directed payment initiative estimated at \$28 million for certain eligible HCBS state plan services (pending CMS approval). Rates for directed payments do not include an additional allowance for administrative expense or risk margin for this addition. The directed payment is subject to premium tax.

b. State Legislative benefit updates

i. Home visiting services for pregnant women and infants ages 0-1 year consistent with HB 2 beginning October 1, 2021, were prorated 9-months at estimated annual costs of \$1.853 million.

ii. Genetic testing reimbursement for hospitals in accordance with HB 600.

5. Fee schedule updates, include:

a. DRG inpatient hospital unit cost trend updates using the actual 2022 DRG weights effective October 1, 2021. A review of the newly released weights suggests a 0.0% unit cost trend between 2021 and 2022 compared to the Amendment #6 assumption of a 0.56% increase based on historical data.

b. Neuro-psychiatric testing codes within the Calendar Year 2021 fee schedule included a number of incorrect entries for several neuro-psychiatric testing codes which prompted an update to reimbursement adjustment factors. The estimated impact of the correction is an increase of approximately \$135,000 for SFY 2022.

c. Other fee schedule changes, include:

i. Unit cost adjustment for latex gloves and a fee schedule update for vaccine administration account for an additional \$310,000 in SFY 2022.

ii. New durable medical equipment (DME) and supplies (breast milk storage bags, peristeen pumps) with annual costs estimated at \$280,200 and \$135,000, respectively (effective October 1, 2021).

iii. Behavioral health crisis treatment center program services transferring to the State's redesigned Mobile Crisis Response Program.

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- iv. Preferred drug list (PDL) updates to include different formulations of drugs already included on the PDL.
- v. Community residential services beds service projection updates.

6. Prescription drug savings adjustments

An adjustment to rates is included to account for differences in MCO pharmacy management (e.g., adherence to generally accepted quantity limits for three (3) therapeutic classes, opioid prescribing patterns, prior authorization denial rates) with annual savings of \$1.59 million incorporated into the rates.

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session. In the event the contract is not approved, available federal relief to HCBS providers and their direct care workers would not be available.

Respectfully submitted,



Lori A. Shibinette
Commissioner

Medicaid Care Management Services Contract Amendment #7 Fiscal Details

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, GRANTEE ADVANTAGE HEALTH PROGRAM TRUST FUND					
State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	\$478,176,246	\$97,592,235	\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,320,354,798	\$97,592,235	\$1,417,947,033
05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$105,226,028	(\$2,874,524)	\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$224,100,386	(\$2,874,524)	\$221,225,863
05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$605,258,297	\$13,175,440	\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,693,445,442	\$13,175,440	\$1,706,620,882
		<i>Amendment #7</i>	Current Budget	Increase / (Decrease)	Revised Budget
		Total Funds	\$3,237,900,627	\$107,893,151	\$3,345,793,778

**Medicaid Care Management Services Contract
Amendment #7 Fiscal Details**

Table 1A
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2022 Capitation Rate Change
Based on Projected SFY 2022 Enrollment by Rate Cell
Excluding Directed Payments

Population	Amendment #6 SFY 2022 Capitation Rate (assuming PHE ends in December 2021)	Amendment #7 SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$333.44	\$329.75	-1.1%
CHIP	198.87	196.50	-1.2%
Behavioral Health Population	1,362.27	1,369.33	0.5%
Total Standard Medicaid	\$393.22	\$390.53	-0.7%
Granite Advantage Health Care Program			
Medically Frail	\$1,102.60	\$1,091.37	-1.0%
Non-Medically Frail	434.71	418.97	-3.6%
Behavioral Health Population	1,924.66	1,937.48	0.7%
Total GAHCP	\$584.51	\$569.64	-2.5%
Grand Total	\$462.92	\$455.79	-1.5%

Table 1B
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2022 Capitation Rate Change
Based on Projected SFY 2022 Enrollment by Rate Cell
Including Directed Payments

Population	Amendment #6 SFY 2022 Capitation Rate (assuming the PHE ends in December 2021)	Amendment #7 SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$344.61	\$354.31	2.8%
CHIP	204.22	202.50	-0.8%
Behavioral Health Population	1,413.46	1,457.38	3.1%
Total Standard Medicaid	\$406.64	\$417.37	2.6%
Granite Advantage Health Care Program			
Medically Frail	\$1,154.24	\$1,144.47	-0.8%
Non-Medically Frail	449.47	432.79	-3.7%
Behavioral Health Population	1,960.95	2,005.23	2.3%
Total GAHCP	\$604.49	\$590.37	-2.3%
Grand Total	\$478.73	\$480.41	0.3%

**Medicaid Care Management Services Contract
Amendment #7 Fiscal Details**

Table 2 New Hampshire Department of Health and Human Services Amendment #6 vs. Amendment #7 SFY 2022 MCM Capitation Rate Change by Component¹ Based on Projected SFY 2022 Enrollment by Rate Cell						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Program Changes						
Benefit Updates	0.2%	\$1,760,394	0.0%	\$114,928	0.1%	\$1,875,322
Allowance for Genetic Testing for Hospitals per HB 600	0.0%	120,592	0.0%	-	0.0%	120,592
Behavioral Health Crisis Treatment Center Update	0.0%	(28,652)	0.0%	(87,990)	0.0%	(116,642)
Home and Community Based Services Directed Payment (TBD)	3.4%	24,176,318	0.7%	4,334,931	2.2%	28,511,250
Total Program Changes	3.7%	\$26,028,652	0.7%	\$4,361,870	2.3%	\$30,390,522
Other Changes Relative to Amendment #6 Rating Assumptions						
Fee Schedule and DRG Trend Updates	0.0%	\$136,594	0.0%	(\$163,400)	0.0%	(\$26,805)
Update to Community Residential Services Bed Projections	0.0%	38,651	0.0%	6,452	0.0%	45,104
PDL Update	0.0%	128,414	0.0%	(74,195)	0.0%	54,219
Acuity Adjustment Update	-0.7%	(4,885,580)	-1.8%	(11,050,153)	-1.2%	(15,935,733)
Prescription Drug Savings	-0.1%	(974,522)	-0.2%	(1,165,118)	-0.2%	(2,139,640)
PMPM Impact of Updated Enrollment Projections on Fixed Dollar Rate Components	-0.3%	(1,826,101)	-1.0%	(5,986,171)	-0.6%	(7,812,272)
Total Other Changes	-1.0%	(\$7,382,543)	-3.1%	(\$18,432,585)	-2.0%	(\$25,815,127)
Total Rate Change for SFY 2022 Relative to Amendment #6 Rates	2.6%	\$18,646,109	-2.3%	(\$14,070,715)	0.3%	\$4,575,394

¹The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.

MAY 27 '21 PM 4:23 RCVD

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MAR

Lori A. Shibinette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

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May 27, 2021

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total shared price limitation by \$1,188,660,571 from \$2,049,240,056 to \$3,237,900,627, with no change to the completion date of August 31, 2024 effective July 1, 2021 or upon Governor and Council approval, whichever is later. Funding sources are as follows:

	Federal	Other	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	71.88%	0.50%	27.62%
Standard Medicaid Population (Medicaid Care Management Account)	53.12%	22.56%	24.32%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of federal medical assistance percentage (FMAP) for the CHIP population could become available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. Additionally, the American Rescue Plan of 2021 potentially provides an additional 10% FMAP for a one year period (April 1, 2021-March 31, 2022) for certain home and community based services covered in this contract based on approved Centers for Medicare and Medicaid Services (CMS) spending plan, which is subject to further federal guidance at this juncture. If the additional funding is received the Department will request Fiscal Committee authority to accept, and expend additional amounts for January 2022 forward.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 2 of 5

April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020 (Item #6), and January 22, 2021 (Item #9).

Funds are available in the accounts outlined in the attached fiscal details for State Fiscal Year (SFY) 2021, and are anticipated to be available in the SFYs 2022 through 2023 with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

CMS requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2023.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes and legislatively approved rate increases are included as well.

EXPLANATION

This request covers the rating period of July 1, 2021 through June 30, 2022.

Summary of Key Changes

Exhibit A. Program Change Summary:

1. A carry forward of staffing requirements from amendment #5
2. Added provision that Members shall not be required to change covered prescription drugs more than once per calendar year, with limited exceptions.
3. Further extension of additional preferential auto-assignment awards for high-performing MCO(s) consistent with Alvarez & Marsal's report recommendation incorporated initially the last MCO contract amendment.
4. New CMS Managed Care Rule provisions effective July 1, 2021 concerning beneficiary/member rights.
5. Update to the National Committee for Quality Assurance (NCQA) reporting compliance requirements.
6. New Directed Payment for Community Residential Services provided by Community Mental Health Centers (CMHCs) and Psychiatric Designated Receiving Facilities (DRFs); continuation of Directed Payments for Durable Medical Equipment (DME), CMHCs, and Critical Access Hospitals (CAHs).
7. The inclusion of CMS requested language for historical directed payments terms.
8. Elimination of risk corridor and replacement with Minimum and Maximum Medical Loss Ratios (MLRs), the effect of which reduces the state's risk compared to the SFY 2020 and 2021 Risk Corridors. The state has greater enrollment risk due to the unpredictable length of the federal public health emergency.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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9. The minimum MLR is set at 88.2% for the Standard Medicaid population and 87.4% for the Granite Advantage Health Care Program (GAHCP) population. The maximum MLR shall be 94.2% for the Standard Medicaid population and 93.4% for the GAHCP population.

10. Any incentive payments made to higher-performing MCOs as part of the Withhold and Incentive Program shall not impact the minimum or maximum MLR provision of the contract.

11. For the period July 1, 2021 through June 30, 2022 rating period, MCOs will receive a one-time kick payment for each Member psychiatric admission stay with DRG code 880-887 subject to limited exceptions.

12. Sets the MCO administrative allowance for SFY 2022 at the 40th percentile, or \$35.78 PMPM (Per Member Per Month) SFY 21 had a blended administrative allowance of \$37.00 PMPM.

The state's actuary Milliman used the following methodology to develop the New Hampshire MCM program capitation rates:

1. Summarize CY 2018 and CY 2019 MCO encounter experience data for the Standard Medicaid and GAHCP Medically Frail eligible population and the March 2019 to December 2019 MCO encounter data for the GAHCP Non-Medically Frail population.
2. Project estimated statewide SFY 2022 MCM program medical costs for all covered services by rate cell.
3. Blend the projected SFY 2022 costs based on CY 2018 and CY 2019 encounter data.
4. Adjust SFY 2022 projected medical costs for all rate cells for benefits not included in the base experience data, expected administrative expenses, margin, and premium tax.

Medicaid enrollment is projected to remain elevated through the end of the federal Department of Health and Human Services declared PHE. There still exists uncertainty related to the end of the PHE. As such, Milliman prepared two (2) separate enrollment scenarios: 1) the PHE ends December 2021, and 2) the PHE ends September 2021:

- Each scenario assumes enrollment returning to pre-COVID levels due to the reinstatement of eligibility redetermination activities three (3) months following the end of the PHE.
- The changes in enrollment are anticipated to impact the average acuity of beneficiaries. For rate cells modeled to have significant enrollment differences due to the PHE; newer enrollees having lower illness burden, the rate development includes an acuity adjustment for each scenario.
- The Department will initially pay capitation rates based on the December 2021 scenario, but will retroactively pay capitation rates under the September 2021 scenario if the PHE ends prior to October 1, 2021.

The capitation rates do not include provisions for expected vaccination administration fees related to COVID-19 in SFY 2022. The cost of vaccination administration fees remain carved out of the MCM program. Based on the interplay of other funding sources. The SFY 2022 capitation rates do not include any explicit adjustments for the following:

- COVID-19 Testing and Treatment Cost: The prevalence of COVID-19 infection rates in SFY 2022 is dependent on many variables that make it difficult to predict to include an

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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estimate for the cost of testing for and treating individuals with COVID-19 including, but not limited to:

- The take-up rate and timing of COVID-19 vaccinations;
- The emergence of COVID-19 variants and the efficacy of vaccines on these variants; and
- The implementation of social distancing measures.

Milliman advises, there is not a publicly available model that includes COVID-19 infection rate or hospital admissions through June 2022. In addition, the publicly available models have materially changed short-term and long-term projections of COVID-19 prevalence in reaction to emerging data. While Milliman reviewed historical MCM data for the cost of testing and treating COVID-19 in CY 2020, given the unpredictable patterns of COVID-19 prevalence to date in New Hampshire and the changing national models there is a range of potential impacts on the SFY 2022 rates.

The most significant fiscal impact of COVID-19 to date has been the deferral of non-essential services, either through government-enacted policies, the impact of social distancing on the administration of services, or personal choice. Milliman reviewed MCM emerging claims data incurred through February 2021 by population type (to remove the impact of membership mix changes). As of February 2021, there was still measurable reductions in claim costs for each population compared to the PMPMs prior to the pandemic in CY 2019. However, Milliman advises it is difficult to use this historical data to project the impact of deferred services for SFY 2022 for many reasons.

- Utilization by service category has varied in CY 2020 and early CY 2021 as the level of COVID-19 diagnoses and hospital admissions has changed in New Hampshire over the course of the pandemic. Therefore, the unknown future prevalence of COVID-19 will be a key variable in future service utilization changes relative to pre-pandemic levels.
- Limited data is available to understand how beneficiary behavior will change during and after the roll-out of the COVID-19 vaccination. As such, there could still be a wide range of possibilities as to when service utilization may return to pre-pandemic levels or if there will be increased utilization due to pent up demand.
- In the MCM data Milliman reviewed it is difficult to isolate the impact of deferred services from changes in utilization due to other drivers, such as member acuity changes or change in service mix.


His Excellency, Governor Christopher T. Sununu
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In response to the pandemic, the mix of services used to treat patients has changed, such as the use of telehealth services. It is unknown if these provider and patient changes will persist after the end of the pandemic.

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP necessary to cover the program are not sufficient, the projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shibinette
Commissioner

**Medicaid Care Management Services Contract
Amendment #6 Fiscal Details**

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	TBD	\$478,176,246	\$478,176,246
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$842,178,552	\$478,176,246	\$1,320,354,798

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	TBD	\$105,226,028	\$105,226,028
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$118,874,358	\$105,226,028	\$224,100,386

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	TBD	\$605,258,297	\$605,258,297
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$1,088,187,145	\$605,258,297	\$1,693,445,442
Grand Total			\$2,049,240,056	\$1,188,660,571	\$3,237,900,627

**Medicaid Care Management Services Contract
Amendment #6 Fiscal Details**

Table 1A
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2022 Capitation Rate Change
Based on Projected SFY 2022 Enrollment by Rate Cell
Excluding Directed Payments – PHE Ending December 2021

Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$323.46	\$334.52	3.4%
CHIP	183.38	196.79	7.3%
Behavioral Health Population	1,398.23	1,362.47	-2.6%
Total Standard Medicaid	\$387.45	\$395.22	2.0%
Restated Total Standard Medicaid¹	\$387.45	\$398.48	2.8%
Granite Advantage Health Care Program			
Medically Frail	\$1,201.72	\$1,102.08	-8.3%
Non-Medically Frail	456.03	434.66	-4.7%
Behavioral Health Population	1,966.46	1,883.55	-4.2%
Total GAHCP	\$604.71	\$577.79	-4.5%
Restated Total GAHCP¹	\$604.71	\$578.69	-4.3%
Grand Total	\$457.62	\$454.19	-0.8%
Restated Grand Total¹	\$457.62	\$456.68	-0.2%

¹ Removes community residential service costs from January 2021 to June 2021 capitation rates to allow for a consistent comparison since those service costs will move into a directed payment for SFY 2022.

Table 1B
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2022 Capitation Rate Change
Based on Projected SFY 2022 Enrollment by Rate Cell
Excluding Directed Payments – PHE Ending September 2021

Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$321.40	\$334.56	4.1%
CHIP	182.99	197.56	8.0%
Behavioral Health Population	1,376.46	1,361.95	-1.1%
Total Standard Medicaid	\$379.07	\$390.43	3.0%
Restated Total Standard Medicaid¹	\$379.07	\$393.77	3.9%
Granite Advantage Health Care Program			
Medically Frail	\$1,201.72	\$1,124.54	-6.4%
Non-Medically Frail	456.03	442.13	-3.0%
Behavioral Health Population	1,966.55	1,923.25	-2.2%
Total GAHCP	\$606.10	\$589.77	-2.7%
Restated Total GAHCP¹	\$606.10	\$590.79	-2.5%
Grand Total	\$448.95	\$451.79	0.6%
Restated Grand Total¹	\$448.95	\$454.42	1.2%

¹ Removes community residential service costs from January 2021 to June 2021 capitation rates to allow for a consistent comparison since those service costs will move into a directed payment for SFY 2022.

**Medicaid Care Management Services Contract
Amendment #6 Fiscal Details**

Table 1C New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Including Directed Payments – PHE Ending December 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$334.19	\$345.73	3.5%
CHIP	188.46	202.02	7.2%
Behavioral Health Population	1,447.43	1,455.31	0.5%
Total Standard Medicaid	\$400.38	\$411.91	2.9%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.31	\$1,154.24	-6.6%
Non-Medically Frail	474.37	449.47	-5.2%
Behavioral Health Population	2,004.30	1,937.80	-3.3%
Total GAHCP	\$625.70	\$598.45	-4.4%
Grand Total	\$473.15	\$472.16	-0.2%

Table 1D New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Including Directed Payments – PHE Ending September 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$332.13	\$346.06	4.2%
CHIP	188.05	202.92	7.9%
Behavioral Health Population	1,426.26	1,463.18	2.6%
Total Standard Medicaid	\$391.87	407.59	4.0%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.31	\$1,181.62	-4.4%
Non-Medically Frail	474.37	458.53	-3.3%
Behavioral Health Population	2,004.39	1,985.83	-0.9%
Total GAHCP	\$627.10	\$612.72	-2.3%
Grand Total	\$464.27	\$470.73	1.4%

Medicaid Care Management Services Contract Amendment #6 Fiscal Details

Table 2
New Hampshire Department of Health and Human Services
SFY 2022 MCM Capitation Rate Change by Component¹
Based on Projected SFY 2022 Enrollment by Rate Cell
PHE Ending in December 2021

Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Program Changes						
MCRT / ES Services Carve Out	-0.4%	(\$2,511,022)	-0.3%	(\$1,340,348)	-0.3%	(\$3,851,370)
Change to Hospital Directed Payment ²	-0.1%	(399,878)	-0.1%	(354,365)	-0.1%	(754,243)
Increase to Community Residential Services Reimbursement Incorporated into New Directed Payment	0.3%	1,810,745	0.0%	174,077	0.2%	1,984,822
Total Program Changes	-0.2%	(\$1,100,155)	-0.3%	(\$1,520,636)	-0.2%	(\$2,620,791)
Other Changes Relative to January 2021 to June 2021 Rating Assumptions						
Administrative Allowance Increase	0.9%	\$6,083,179	0.9%	\$4,693,554	0.9%	\$10,776,732
Acuity Adjustment Related to Increased MCM Program Enrollment	-1.0%	(7,125,086)	-1.3%	(6,712,787)	-1.2%	(13,837,873)
Change to Boston Children's Hospital Funding	0.0%	102,338	0.0%	6,968	0.0%	109,306
Change to PDL Adjustment Assumptions	0.6%	4,011,893	0.3%	1,502,964	0.5%	5,514,857
Change to Prescription Drug Trend Assumptions	-1.0%	(7,104,913)	-2.1%	(10,731,192)	-1.5%	(17,836,105)
Change to Outpatient Reimbursement Trend Assumptions	0.6%	4,100,658	0.7%	3,320,370	0.6%	7,421,028
Removal of SFY 2021 COVID-19 Adjustment	2.8%	19,122,578	-0.6%	(2,883,904)	1.4%	16,238,674
Impact of MCO PBM Change	-0.4%	(2,622,185)	-0.5%	(2,676,315)	-0.4%	(5,298,501)
Minimum DME Fee Schedule Evaluation Approach	-0.8%	(5,684,056)	-0.6%	(2,958,499)	-0.7%	(8,642,555)
Base Data Change and Other	1.4%	9,840,615	-0.8%	(4,162,099)	0.5%	5,678,515
Total Other Changes	3.0%	\$20,725,018	-4.1%	(\$20,600,940)	0.0%	\$124,078
Total Rate Change for SFY 2022 Relative to January 2021 to June 2021 Rates	2.9%	\$19,624,863	-4.4%	(\$22,121,576)	-0.2%	(\$2,496,713)

¹ The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.

² The change in hospital directed payment represents the incremental change from the \$33.7 million included in the SFY 2021 capitation rates. The total hospital directed payment is \$33 million for SFY 2022.



Lori A. Shibley
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

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December 30, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into **Retroactive** amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by decreasing the total shared price limitation by \$128,374,314 from \$2,177,614,370 to \$2,049,240,056, with no change to the completion date of August 31, 2024 effective retroactive to July 1, 2020 upon Governor and Council approval.

Funds for Granite Advantage Health Program (GAHCP) are 90% Federal and 10% Other (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 74.23% Federal and 25.77% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 52.5% Federal, 24.15% General and 23.35% Other funds. An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population could become available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. If the forgoing materialize, DHHS would go to the Fiscal Committee to increase, accept, and expend amounts for January 2021 forward.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), and most recently amended with Governor and Council approval on June 10, 2020 (Item #6).

Funds are available in the accounts outlined in the financial section for State Fiscal Year 2021, and are anticipated to be available in the State Fiscal Years 2022 through 2025, with authority to adjust amounts within the price limitation between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for State Fiscal Years 2020-2021.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 2 of 3

See attached fiscal details.

EXPLANATION

This request is **Retroactive** because this Amendment covers the retrospective rating period July 1, 2020 through June 30, 2021. The State negotiated in the original SFY2021 rates the opportunity to refresh actuarial estimates. The State was able to use this added flexibility from CMS due to the Public Health Emergency, uncertainties related to COVID-19 treatment and costs, and utilization impact on non-COVID services. The most material initial actuarial estimate was for the costs of deferred care from the prior contract period. As the Public Health Emergency has continued this became a key assumption to revisit as has the enrollment and the composition thereof.

Fiscal table budget amounts reflect more current utilization and enrollment experience, enhanced FMAP available and accepted thus far. Adjustments to administrative costs, program changes and legislatively approved rate increases are included as well.

CMS published a new Medicaid Managed Care rule in November 2020 with provisions effective either December 14, 2020 or July 1, 2021. Those provisions taking effect in December 2020 are incorporated herein and are procedural rather than economic in impact to this Agreement.

Summary of Key Changes

The reduction in price limitation reflects a slightly less steep enrollment growth based on the State of New Hampshire's employment recovery with a greater than expected length of the PHE and maintenance of effort required to earn the enhanced FMAP. DHHS had forecast average monthly enrollment for the contract year of just over 215,000 people, whereas based on experience DHHS now forecast about 208,000 people. This reduction along with a 3% reduction globally in the capitation rates to be paid to the MCOs accounts for the favorable price limitation change.

The 3% capitation rate reduction is a function of net changes; totaling \$38,077,712. The single largest favorable change is related to more favorable COVID-19 cost experience of \$30,774,811. Rather than a 1.2% increase in this SFY 21 period for care deferred care before June 30, 2020, the adjustment for the full twelve month period is a 1.3% decrease.

The second largest favorable adjustment is for MCO administrative costs of \$17,406,265 (or 2.5% of capitation excluding directed payments and premium tax) for the period of January through June, 2021. This reduction reflects an analysis of what the PHE has permitted the MCOs to implement under the contract, what is likely to be able to be advanced in this period given an extension of the PHE due to waves of COVID-19 surge as well as recalibration of those activities where the return on investment looks longer than anticipated back when the contract was developed.

These and other administrative allowance adjustments represent an adjusted administrative allowance consistent with the 50th percentile for the full period (previously, the 75th percentile) and the 32nd percentile for the last six months. Administrative cost benchmarks of other Medicaid managed care plans and within the MCM program were assessed by the state's actuaries.

Offsetting these two key favorable cost adjustments are increases related to the HB4 3.1% provider rate increase amounting to \$13,775,736 for the period January through June 2021 and an increase in the Boston Children's Hospital risk pool of \$4,847,238 for the full twelve month period

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 3 of 3

reflecting more recent reported experience, other changes can be seen in Table A. The resulting composite capitation rates can be seen in Table B; the net is a 3% reduction.

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 90% Federal and 10% Other; funds for the Child Health Insurance Program are 74.23% federal as appropriated by Congress and 25.77% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 52.50% Federal as appropriated by Congress, 24.15% General and 23.35% Other funds.

In the event that the non-federal Other funds for the GAHCP necessary to cover the program are not sufficient, the projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shibinette
Commissioner

**Medicaid Care Management Services Contract
Amendment #5 Fiscal Details**

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$598,415,047	(\$64,904,641)	\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$907,083,193	(\$64,094,641)	\$842,178,552

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$70,490,459	(\$7,484,764)	\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$126,359,123	(\$7,484,764)	\$118,874,358

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$692,143,775	(\$55,984,909)	\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$1,144,172,054	(\$55,984,909)	\$1,088,187,145
Grand Total			\$2,177,614,370	(\$128,374,314)	\$2,049,240,056

Medicaid Care Management Services Contract Amendment #5 Fiscal Details

Table A						
New Hampshire Department of Health and Human Services						
SFY 2021 MCM Capitation Rate Change by Component¹						
Based on Projected SFY 2021 Enrollment by Rate Cell						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Program Changes						
2021 DRG fee schedule	0.0%	(\$247,823)	0.0%	(\$251,060)	0.0%	(\$498,883)
Stop loss attachment point indexing	0.0%	265,222	0.0%	-	0.0%	265,222
Removal of MCO psychiatric consult service	0.0%	(181,666)	0.0%	(128,796)	0.0%	(310,462)
Administrative allowance changes related to MCM contract restructuring and benchmarking	-1.3%	(9,169,440)	-1.5%	(8,236,825)	-1.4%	(17,406,265)
House Bill 4 3.1% provider rate increase	1.1%	7,860,466	1.1%	5,915,270	1.1%	13,775,736
Updated DME fee schedule	0.0%	99,383	0.0%	14,580	0.0%	113,962
Fee schedule changes related to Medicare	0.0%	(218,541)	0.0%	(211,407)	0.0%	(429,947)
Total Program Changes	-0.2%	(\$1,592,398)	-0.5%	(\$2,898,238)	-0.4%	(\$4,490,636)
Other Changes						
COVID adjustment impact	-3.8%	(\$26,877,600)	-0.7%	(\$3,897,211)	-2.5%	(\$30,774,811)
Increase to BCH risk pool	0.7%	4,782,251	0.0%	64,987	0.4%	4,847,238
Behavioral Health Crisis Treatment Center utilization adjustment	0.0%	(160,346)	0.0%	(20,322)	0.0%	(180,669)
PMPM recalibration of fixed dollar rate components	-0.1%	(464,544)	-0.1%	(416,071)	-0.1%	(880,615)
Enhanced TPL recoveries and cost avoidance activities	-0.1%	(881,248)	-0.1%	(705,194)	-0.1%	(1,586,442)
Enhanced PDL compliance	0.0%	(75,548)	0.0%	(83,591)	0.0%	(159,139)
Voluntary Psychiatric Admissions	0.1%	377,733	0.3%	1,542,363	0.2%	1,920,097
Base data change and other	-0.1%	(868,319)	-1.1%	(5,904,416)	-0.5%	(6,772,736)
Total Other Changes	-3.4%	(\$24,167,621)	-1.7%	(\$9,419,455)	-2.7%	(\$33,587,076)
Total Rate Change for SFY 2021 Relative to Original SFY 2021 Rates	-3.7%	(\$25,760,019)	-2.2%	(\$12,317,693)	-3.0%	(\$38,077,712)

¹ The various rate change components include the impact of attributed administrative allowance, risk / profit margin and premium tax beyond the service costs alone.

**Medicaid Care Management Services Contract
Amendment #5 Fiscal Details**

Table B					
New Hampshire Department of Health and Human Services					
Medicaid Care Management Program					
SFY 2021 Capitation Rate Change					
Based on Projected SFY 2021 Enrollment by Rate Cell¹					
Population	Original SFY 2021 Capitation Rate Adjusted for Enrollment Mix	Updated July 2020 to Dec 2020 Capitation Rate	Updated Jan 2021 to June 2021 Capitation Rate	Updated SFY 2021 Capitation Rate ²	Percentage Change from Original SFY 2021 Rate
Standard Medicaid					
Base Population	\$350.81	\$336.50	\$336.84	\$336.68	-4.0%
CHIP	198.67	193.77	187.23	190.30	-4.2%
Behavioral Health Population	1,460.51	1,401.17	1,442.01	1,422.21	-2.6%
Total Standard Medicaid	\$418.14	\$402.24	\$403.36	\$402.82	-3.7%
Granite Advantage Health Care Program					
Medically Frail	\$1,273.88	\$1,246.34	\$1,236.31	\$1,241.25	-2.6%
Non-Medically Frail	486.18	481.16	474.37	477.49	-1.8%
Behavioral Health Population	2,086.30	2,097.98	1,996.27	2,010.49	-3.6%
Total GAHCP	\$664.64	\$655.36	\$644.82	\$649.69	-2.2%
Grand Total	\$499.20	\$483.07	\$484.85	\$484.00	-3.0%

¹ Projected enrollment reflects DHHS estimates provided on December 9, 2020, with 1,193,381 member months for July 2020 to December 2020 and 1,312,169 member months for January 2021 to June 2021.

² The updated SFY 2021 capitation rates are a blend of the July 2020 to December 2020 rates and the January 2021 to June 2021 rates based on projected member months by rate cell.

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

Lori A. Shibiante
Commissioner

Henry D. Lipman
Director

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603-271-9389 1-800-852-3345 Ext. 9389
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May 26, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to retroactively amend existing agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schrafft's City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), and by increasing the shared price limitation by \$1,361,049,281 from \$816,565,089 to an amount not to exceed \$2,177,614,370, with no change to the completion date of August 31, 2024, effective upon Governor and Executive Council approval.

Funds for Granite Advantage Health Program (GAHCP) are 90% Federal and 10% Other (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 67.88% Federal and 32.12% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51.01% Federal, 22.56% General and 26.43% Other funds. An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population could become available if the public health emergency (PHE) continues. The CARES Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. The funding percentage of the Child Health Insurance Program (CHIP) is already subject to enhancement through September 2020; the CARES Act would enhance that to 80.84% if the PHE continues into the first quarter of State Fiscal Year 2021. If the forgoing materialize, DHHS would go to the Fiscal Committee to increase, accept, and expend amounts.

This agreement was originally approved by the Governor and Executive Council on March 27, 2019 (Tabled Late Item A), and subsequently amended on April 17, 2019 (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A).

Funds are available in the following accounts for State Fiscal Year 2021, and are anticipated to be available in the State Fiscal Years 2022 through 2025, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office; if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align

His Excellency, Governor Christopher T. Sununu
 and the Honorable Council
 Page 2 of 6

with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for State Fiscal Year 2021.

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
 MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	TBD	\$598,415,047	\$598,415,047
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$308,668,146	\$598,415,047	\$907,083,193

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
 MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	TBD	\$70,490,459	\$70,490,459
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$55,868,664	\$70,490,459	\$126,359,123

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
 MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	TBD	\$692,143,775	\$692,143,775
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$452,028,279	\$692,143,775	\$1,144,172,054
<i>Grand Total</i>			\$816,565,089	\$1,361,049,281	\$2,177,614,370

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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EXPLANATION

This request covers the period July 1, 2020 through June 30, 2021 (prior contract period was a ten month period). The amounts herein make an initial actuarial estimate for the costs of deferred care from the prior contract period. The budget amounts in the fiscal tables reflect enrollment experience and trend as a result of the public health emergency and the maintenance of effort requirements. Thus far through May 22, 2020, from the date of the PHE, total enrollment has increased overall by more than 7% with the Granite Advantage Health Care Program (GAHCP) over 11%. For State Fiscal Year 2021, enrollment is projected to increase additionally 5.3% for the standard population and 16.5% for the GAHCP.

There is undoubtedly, a high level of uncertainty for future COVID-19 treatment and testing costs, and the acuity of the spike in new enrollment due to the effects of the COVID-19 and the PHE and related economic conditions. Additionally, the impacts on future utilization and deferred care, unrelated to COVID-19 are not reliably known. Therefore, DHHS proposes a retroactive actuarial rate refresh based on experience from the first quarter of the contract back to July 1, 2020 to incorporate more recent actuarial experience, HB 4 rate adjustments, and any further legislative policy changes. The retroactive actuarial rate refresh will necessitate another contract amendment anticipated in February 2021.

Summary of Changes

The amendment to the three (3) MCM capitated and risk-based vendor Agreements, including capitation rate adjustments for September 2019 to June 2020, and July 2020 through June 2021, as well as Exhibit A narrative contract changes, reflect the following changes:

The State Fiscal Year 2021 capitation rates below reflect three program changes from the September 2019 to June 2020 capitation rates.

They are:

1. Revised rate cell structure that incorporates the GAHCP Behavioral Health population into the existing Behavioral Health rate cells and a separate Children's Health Insurance Program (CHIP) rate cell;
2. Targeted savings opportunities through increased care management activities consistent with the MCM contract effective September 1, 2019; and
3. Implementation of a hospital directed payment to promote access to high-quality acute care services provided by critical access and non-critical access hospitals across New Hampshire.

The State Fiscal Year 2021 capitation rates include a continued five million dollar directed payment to community mental health centers (CMHCs), and a new thirty million dollar directed payment to hospitals (both subject to CMS approval). While the amounts are included in the MCO capitation rates, the MCOs are not at-risk for the amount of these directed payments. Both directed payments are included to support quality and access initiatives of the MCM Program.

Capitation Rate Tables 1A and 1B below show the statewide rate change by population compared to the September 2019 to June 2020 capitation rates included in the April 22, 2020 rate certification. The two tables compare rates with and without the new hospital directed payment.

Table 1A capitation rates exclude the new hospital directed payment.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Table 1A New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2021 Capitation Rate Change Based on Projected SFY 2021 Enrollment by Rate Cell Excluding Hospital Directed Payment			
Population	September 2019 to June 2020 Capitation Rate	SFY 2021 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$329.36	\$342.73	4.1%
CHIP*	199.95	196.42	-1.8%
Behavioral Health Population	1,445.57	1,430.00	-1.1%
Total Standard Medicaid	\$405.24	\$414.21	2.2%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.85	\$1,239.29	0.2%
Non-Medically Frail	475.21	467.84	-1.6%
Behavioral Health Population**	999.67	2,046.46	104.7%
Total GAHCP	\$621.60	\$651.65	4.8%
Grand Total	\$469.36	\$484.58	3.2%

*The September 2019 to June 2020 capitation rates did not have a separate rate cell for the CHIP population. Most CHIP members were included in the Low Income Children and SED rate cells. The SFY 2021 CHIP population includes CHIP members enrolled in the CHIP and SED rate cells.

**The September 2019 to June 2020 GAHCP capitation rates did not have a separate rate cell for the GAHCP behavioral health population. GAHCP behavioral health population members were included in the Medically Frail and Non-Medically Frail capitation rates. The GAHCP behavioral health population will receive the behavioral health population capitation rates for SFY 2021.

Table 1B includes capitation rates with inclusion of the new hospital directed payment.

Table 1B New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2021 Capitation Rate Change Based on Projected SFY 2021 Enrollment by Rate Cell Including Hospital Directed Payment			
Population	September 2019 to June 2020 Capitation Rate	SFY 2021 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$329.36	\$353.36	7.3%
CHIP*	199.95	200.30	0.2%
Behavioral Health Population	1,445.57	1,446.23	0.0%
Total Standard Medicaid	\$405.24	\$424.48	4.7%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.85	\$1,273.88	3.0%
Non-Medically Frail	475.21	486.18	2.3%
Behavioral Health Population**	999.67	2,069.51	107.0%
Total GAHCP	\$621.60	\$672.86	8.2%
Grand Total	\$469.36	\$498.09	6.1%

*The September 2019 to June 2020 capitation rates did not have a separate rate cell for the CHIP population. Most CHIP members were included in the Low Income Children and SED rate cells. The SFY 2021 CHIP population includes CHIP members enrolled in the CHIP and SED rate cells.

**The September 2019 to June 2020 GAHCP capitation rates did not have a separate rate cell for the GAHCP behavioral health population. GAHCP behavioral health population members were included in the Medically Frail and Non-Medically Frail capitation rates. The GAHCP behavioral health population will receive the behavioral health population capitation rates for SFY 2021.

It should be emphasized that capitation rates are a projection of future costs for an efficient MCO based on a set of assumptions. Actual MCO costs will be dependent on each MCO's

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 5 of 6

situation and the extent to which future experience conforms to the assumptions made in the capitation rate development calculations.

The amendment also includes narrative and other content changes as described below.

They include:

1. Transitional housing program services and community residential services wrap-around services and supports benefit start date from July 1, 2020 to July 1, 2021;
2. Reference to payments standards for directed payments described in actuarial certification materials for the rating period;
3. Change in delivery timeframes for DHHS notice of MCM Withhold and Incentive Program Guidance from within ninety (90) calendar days of the start of the program year to August 1st each year;
4. Explanation that any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period;
5. With alternate instructions from CMS, full replacement of CMS-mandated contract language that directs administration and funds previously appropriated for the GAHCP community engagement requirements administered through the managed care contracts;
6. Provision for a retroactive rate refresh effective July 1, 2020 targeted for February 2021 to address the PHE and related economic and healthcare conditions;
7. Inclusion of a risk corridor protection for the July 2020 to June 2021 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic and the PHE; and
8. Technical corrections to Exhibit N (Liquidated Damages) referenced contract provisions.

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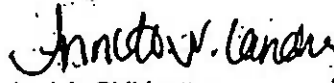
His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 6 of 6

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 90% Federal and 10% Other; funds for the Child Health Insurance Program are 67.88% federal as appropriated by Congress and 32.12% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51.01% Federal as appropriated by Congress, 22.56% General and 26.43% Other funds.

In the event that the non-federal Other funds for the GAHCP necessary to cover the program are not sufficient, the projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



File Lori A. Shibinette
Commissioner



Lori A. Shiolette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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April 24, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to retroactively amend existing agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schrafft's City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM). The shared price limitation remains unchanged, not to exceed \$816,565,089, in State Fiscal Year 2020, retroactive to September 1, 2019 with no change to the completion date of August 31, 2024, effective upon Governor and Executive Council approval. After reconciliation of membership, however, we did a reallocation of funds within the price limitation as reflected in the accounting tables.

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, 1); funds for the Child Health Insurance Program are 77.6% Federal and 22.4% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 22.7% General and 26.3% Other funds.

This agreement was originally approved by the Governor and Executive Council on March 27, 2019 (Tabled Late Item A), and subsequently amended on April 17, 2019 (Item #9), and December 18, 2019 (Item #15).

Funds are available in the following accounts for State Fiscal Year 2020, and are anticipated to be available in the State Fiscal Years 2021 through 2025, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for State Fiscal Year 2020.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 2 of 6

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$316,129,763	(\$7,461,617)	\$308,668,146
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$316,129,763	(\$7,461,617)	\$308,668,146

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$55,047,886	\$820,778	\$55,868,664
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$55,047,886	\$820,778	\$55,868,664

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$445,387,440	\$6,640,839	\$452,028,279
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$445,387,440	\$6,640,839	\$452,028,279

Grand Total	\$816,565,089	\$0	\$816,565,089

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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EXPLANATION

This request is retroactive to September 1, 2019 in order to reallocate 1.5% of the capitation payments to ensure access to care for Medicaid beneficiaries and help provide financial stability for safety-net providers. Network providers' provision of access to Medicaid beneficiaries could decrease without consideration of the impact of COVID-19. The directed payments described herein are intended to help, in part, providers remain available to beneficiaries and ensure network adequacy under CMS regulations.

In addition, this amendment will address the CMS requirement to strike contract language that directs administration and funds previously appropriated for the Granite Advantage Health Care Program's (GAHCP) community engagement requirements administered through the managed care contracts. This is because Community engagement requirements have been vacated by the court.

Summary of Changes

DHHS therefore proposes to make the following changes to components of the capitation rates in order to fund the proposed directed payment funding pool:

1. Reduce service costs by 1.5% for all services to recognize the expected net impact of reductions in non-emergency and elective service costs due to the COVID-19 pandemic social distancing guidelines, increased COVID-19 treatment costs, the impact of waiving certain prior authorization requirements, and reduced population acuity due to projected enrollment increases related to the recession
 - a. The MCOs have agreed to continue their capitation arrangement with the community mental health centers (CMHCs) at current payment levels and waive any related maintenance of effort (MOE) provisions for state fiscal year (SFY) 2020.
2. Reduce the per member per month (PMPM) administrative allowance for all rate cells by 1.5% to recognize that significantly fewer MCM program members are enrolled in care management programs compared to the 15% expectation in the MCM contract.
3. Further reduce the administrative allowance for the GAHCP Non-Medically Frail population by \$0.45 PMPM to remove costs related to the GAHCP work and community engagement requirement. The related funding is repurposed for the directed payment pool.
4. Reduce the gain/loss margin to reflect the shifting of revenue from at-risk services to the new non-risk directed payments. The gain/loss margin still represents 1.5% of at-risk revenue.
5. Calculate the amount available for the new directed payment funding pool, which is approximately \$11.7 million assuming the original projected enrollment level (i.e., not incorporating likely enrollment growth resulting from the recession).
6. The original CMHC directed payment remains unchanged.
7. The PMPM premium tax allowance remains unchanged because the capitation rates by rate cell are unchanged after the reallocation by component.

Safety-net Provider Directed Payments

Pending CMS approval, DHHS will require each MCO to pay a percentage distribution and initial allocation for specific qualifying services provided by the six safety-net provider classes based on January 2019 to June 2019 MCO encounter payments as described in Table 1 below.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Table 1
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
Initial Allocation of Directed Payment Sub-Pools

Safety-net Provider Class	Percentage Distribution of January to June 2019 MCO Payments for Selected Services Only	Approximate September 2019 to June 2020 Direct Payment (Total)¹	Approximate September 2019 to June 2020 Direct Payment (Monthly)¹
FQHCs and RHCs	32.0%	\$3,744,000	\$374,400
Critical Access Hospitals	29.8%	3,486,600	348,660
SUD Residential Treatment	16.8%	1,965,600	196,560
Home Health	4.9%	573,300	57,330
Private Duty Nursing	8.8%	1,029,600	102,960
Personal Care	7.7%	900,900	90,090
Total Pool	100.0%	\$11,700,000	\$1,170,000

¹ Approximate values of the direct payment pool are based on the initial enrollment projections in the January 14, 2020 rate setting report. Actual monthly pool funding will be determined by actual MCM program enrollment multiplied by the PMPM directed payment funding for each rate cell in the September 2019 to June 2020 MCM program capitation rates.

An identified portion of the actuarially sound per member per month capitation payment to the MCOs multiplied by the member months the plan is paid for the month will form a pool to be used every month to make percentage add-on payments to the defined safety-net provider classes. The pool will be 1.5% of the capitation payments made to the MCOs, or approximately \$12 million for the September 2019 to June 2020 contract year (depending on actual enrollment). DHHS will establish the percentage of the pool that will be allocated to a separate sub-pool for each of the six safety-net provider classes based on historical MCO payments to these providers.

At the end of the month, the amount in each sub-pool will be divided by the payments made by the MCOs to the defined safety-net provider class for qualifying services adjudicated in the month. This calculation will determine the amount of the uniform percentage add-on for the month. The additional payments will be sent to the safety-net providers in the following month. It is anticipated that payments will be made on the following schedule:

- May 2020 payment: based on September 2019 to March 2019 encounters
- June 2020 payment: based on April 2020 encounters
- July 2020 payment: based on May 2020 encounters
- August 2020 payment: based on June 2020 encounters

Every add-on payment will be directly tied to a qualifying paid encounter, and include the ability to tie each payment to a specific service provided to a specific beneficiary through the data consistent with the managed care rule. As warranted to account for changes in the provider environment, CMS has advised that DHHS may amend its directed payment request.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Elements Supporting CMS Approval

The CMS requirement for a directed payment approval under the COVID-19 parameters is to require implementation of a risk corridor for the September 2019 through June 2020 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

In addition, as recommended in CMS guidance documents, additional administrative changes include:

1. For the September 2019 to June 2020 contract year, DHHS shall waive the quality withhold provisions of the Agreement due to the impact of the COVID-19 pandemic.
2. For the May 1, 2020 to June 30, 2020 time period, DHHS shall modify the auto-assignment algorithm to incorporate equal auto-assignment among the three MCOs due to atypical enrollment increase.

Should the Governor and Executive Council not authorize this request beneficiary access and provider stability of safety-net providers will be at greater risk.

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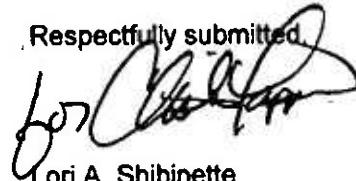
His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 93% federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 77.6% federal as appropriated by Congress and 22.4% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 22.7% General and 26.3% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, sums necessary to cover a projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shibinette
Commissioner

*The Department of Health and Human Services' Mission is to join communities and families
in providing opportunities for citizens to achieve health and independence.*

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Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9389 1-800-852-3345 Ext. 9389
Fax: 603-271-4332 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

December 4, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to retroactively amend existing agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schraffts City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, and by increasing the shared price limitation by \$18,750,925 from \$797,814,164 to an amount not to exceed \$816,565,089, in State Fiscal Year 2020, retroactive to September 1, 2019 with no change to the completion date of August 31, 2024, effective upon Governor and Executive Council approval.

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, -I); funds for the Child Health Insurance Program are 77.6% Federal and 22.4% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 22.7% General and 26.3% Other funds.

This agreement was originally approved by the Governor and Executive Council on March 27, 2019 (Tabled Late Item A), and subsequently amended on April 17, 2019 (Item #9).

Funds are available in the following accounts for State Fiscal Year 2020 and are anticipated to be available in the State Fiscal Years 2021 through 2025, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for State Fiscal Year 2020.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$299,465,981	\$16,663,782	\$316,129,763
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$299,465,981	\$16,663,782	\$316,129,763

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$54,818,300	\$229,586	\$55,047,886
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$54,818,300	\$229,586	\$55,047,886

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$443,529,883	\$1,857,557	\$445,387,440
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$443,529,883	\$1,857,557	\$445,387,440

Grand Total	\$797,814,164	\$18,750,925	\$816,565,089

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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EXPLANATION

This request is retroactive because of the delay in adopting a biennial budget and the need to update the capitated rates to reflect the various provisions of the budget that are incorporated into the Medicaid Care Management Program.

The amendment to the three (3) Medicaid Care Management (MCM) capitated and risk-based Agreements, including adjustments for September 2019 to June 2020 capitation rates for the MCOs and Exhibit A narrative contract changes, reflect the following changes:¹

Minimum Durable Medical Equipment (DME) fee schedule: Effective January 1, 2020, DHHS shall implement a minimum fee schedule DME services. The estimated impact of this change is approximately \$3.2 million over the January 2019 through June 2020 period.

Psychiatric boarding services: To improve continuity of care for mentally ill MCM members, DHHS shall fund psychiatric consultation services for individual in a psychiatric boarding situation. These services shall be effective March 1, 2020. The estimated impact of this change is approximately \$0.1 million over the March 2020 through June 2020 period.

Fee schedule updates: In accordance with annual CMS updates, reimbursement adjustments reflect the State Fiscal Year 2020 Federally Qualified Health Center (FQHC) encounter rates and the October 2019 (Diagnosis-Related Group) DRG rates.

Boston Children's Hospital (BCH) service funding: Funding for inpatient and outpatient BCH services shall reflect recent expenditure patterns prompting implementation of a risk pool in order to better allocate funds. As a result, claims incurred at the facility shall be excluded from stop-loss protections to avoid unintended interactions between the MCM Program's risk pool and stop-loss risk protection features. The estimated impact of this change is approximately \$1.4 million over the September 2019 through June 2020 period.

Non-Emergency Medical Transportation (NEMT) and Community Mental Health Center (CMHC) service costs: Increases in the Non-Medically Frail population's service costs for NEMT and CMHC costs for the January 2019 to June 2019 period warrant an increase to the base period data. The estimated impact of this change is approximately \$3.1 million over the September 2019 through June 2020 period.

MCO supplemental pharmacy rebates: Review of rebate eligible therapeutic classes revealed current spending did not support the preliminary 0.5% supplemental pharmacy rebate assumption; therefore, the rebate assumption is reduced from 0.5% to 0.1%.

Medically frail acuity adjustment: Review of emerging medical loss ratio (MLR) experience for the Medically Frail population indicated a likely difference in member health acuity between the base data period and emerging experience warrants adjustment to the base period data. The estimated impact of this change is approximately \$7.9 million over the September 2019 through June 2020 period.

Medicaid provider rate increases: House Bill 4, Section 348, of the 2019 NH Regular Legislative Session, directs increases to most Medicaid provider rates (excluding prescription drugs, designated receiving facility (DRF), and substance use disorder (SUD) residential treatment services), including State Plan Services and Waiver Programs by 3.1% effective

¹ Federal law requires managed care rates be reviewed no less frequently than a 12-month period. The Department aligns this process with the State Fiscal Year. The certified rate established for the program reflected in this contract is within the Department's budget for State Fiscal Year 2020. As in the past, the Department and Milliman will work with the legislature through the budget process to ensure the program is funded consistent with the budget.

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January 1, 2020, and an additional 3.1% effective January 1, 2021. The estimated impact of this change is approximately \$9.6 million over the January 2020 through June 2020 period.

Designated Receiving Facility (Involuntary) beds and rate increases: House Bill 4, Section 356, of the 2019 NH Regular Legislative Session, authorizes 8 to 10 new DRF beds, and increases the diagnosis related group (DRG) base rate reimbursement for all existing and newly established DRF beds when certain conditions are met. The new rates and additional beds are targeted for implementation on January 1, 2020. The estimated impact of the change is approximately \$2.2 million for the January 2020 through June 2020 period.

Mobile crisis team (MCT): Senate Bill 11, of the 2019 NH Regular Legislative Session, directs DHHS to create a new adult MCT to supplement those already in place. The new MCT is targeted for implementation on April 1, 2020. The estimated impact of this change is \$0.3 million over the April 2020 through June 2020 period.

The rate adjustments for all of the above program changes are for the ten month capitation rate period for Standard Medicaid and NH Granite Advantage Health Care Program for the September 2019 through June 2020 period with comparison to the previously approved rates are described in Table 1 below. The adjustment period is only 10 months because the prior contract was extended by two months to help effectuate the transition period for the new MCO and the new contract, which was approved by the Executive Council for a September 1, 2019 start date. The Department's actuary, Milliman, has certified a rate that is actuarially sound for this program.

Table 1 New Hampshire Department of Health and Human Services Medicaid Care Management Program September 2019 to June 2020 Capitation Rate Change Based on Projected September 2019 to June 2020 MCO Enrollment by Rate Cell			
Population	Original September 2019 to June 2020 Capitation Rate (March 4, 2019 Report)	Revised September 2019 to June 2020 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$316.28	\$325.85	3.0%
CHIP*	197.36	205.47	4.1%
Behavioral Health Population	1,387.60	1,435.06	3.4%
Total Standard Medicaid	\$390.19	\$402.67	3.2%
Granite Advantage Health Care Program			
Medically Frail	\$1,028.86	\$1,242.47	20.8%
Non-Medically Frail	486.09	475.18	-2.2%
Total GAHCP	\$590.15	\$622.28	5.4%
Total	\$446.21	\$464.19	4.0%

*The CHIP capitation rate is an average of the specific rate cells in which CHIP members are enrolled. We do not develop a CHIP specific capitation rate.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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In addition, Exhibit A narrative contract changes include:

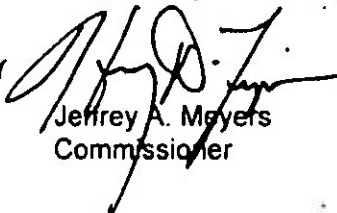
1. Amendment #1 edits carried forward, with adjustments as needed.
2. Transitional housing program services and community residential services: Coverage for these supportive services has been adjusted to reflect a July 1, 2020 start date to correspond with related Request for Proposals activities.
3. Provider payment: Clarifications to provider payments are dependent upon New Hampshire Medicaid fee schedules.
4. Drug Utilization Review (DUR) program: Inclusion of contract provisions to address new federal compliance requirements for the MCM Program's DUR program.
5. Technical corrections: Technical corrections include edits to pharmacy encounter date submission timeframes.
6. Zolgensma: Addition of gene therapy medication, Zolgensma, as a drug covered by New Hampshire Medicaid effective September 1, 2019 due to its extremely high cost and low incidence rate, which makes cost for the treatment difficult to predict for inclusion in MCM capitation rates, including related risk protection processes.
7. Hepatitis C medications: With stabilization of treatment demand, Hepatitis C prescription drugs are carved into the program starting September 2019.
8. Downside risk mitigation: Inclusion of a downside risk mitigation process for the Granite Advantage Health Care Program (GAHCP) Medically Frail and Non-Medically Frail populations for the September 2019 through June 2020 period.
9. Local Care Management: The contract reflects a terminology change, "Local Care Management Network(s)", to better reflect the nature of the program's local care management model.

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 93% federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 77.6 federal as appropriated by Congress and 22.4% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 22.7% General and 26.3% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, sums necessary to cover a projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,

for 
Jeffrey A. Meyers
Commissioner



Jeffrey A. Meyers
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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April 1, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services Office, to amend three (3) Agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schraffts City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, by changing the program start date from July 1, 2019 to September 1, 2019 to accommodate sufficient time for readiness activities needed to effectuate a well-executed implementation of health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, and by decreasing the price limitation by \$126,335,836 from \$924,150,000 to an amount not to exceed \$797,814,164 in State Fiscal Year 2020, for period September 1, 2019 through June 30, 2020, effective upon Governor and Executive Council approval, with a change to the completion date of August 31 2024, from June 30, 2024. The original Agreements were approved by Governor and Executive Council approval on March 27, 2019, Tabled Late Item A (Tabled by Governor and Executive Council on February 20, 2019).

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 78.8% Federal and 21.2% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 24.3% General and 24.7% Other funds.

Funds are anticipated to be available in the following account(s) for State Fiscal Years (SFY) 2020 through 2025 upon the availability and continued appropriation of funds in the future operating budgets. The Centers for Medicare and Medicaid Services (CMS) requires that managed care rate certifications must be done on no more than a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each state fiscal year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how this contract aligns with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for SFY 2020.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
OFC MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$360,150,000	(\$60,684,019)	\$299,465,981
SFY 2021	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$360,150,000	(\$60,684,019)	\$299,465,981

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
OFC MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/ Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$59,700,000	(\$4,881,700)	\$54,818,300
SFY 2021	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$59,700,000	(\$4,881,700)	\$54,818,300

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/ Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$504,300,000	(\$60,770,117)	\$443,529,883
SFY 2021	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$504,300,000	(\$60,770,117)	\$443,529,883
Grand Total			\$924,150,000	(\$126,335,836)	\$797,814,164

EXPLANATION

The purpose of this request is to amend the three (3) Medicaid Care Management (MCM) capitated, and risk-based Agreements by changing the program start date from July 1, 2019 to September 1, 2019. The amendment is necessary to provide a sufficient readiness ramp up period for the Department and the Contractors known as the Managed Care Organizations (MCOs) so the health care services to 180,000 eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, are implemented smoothly, and by decreasing the price limitation by (\$126,335,836) from \$924,150,000 to an amount not to exceed \$797,814,164 in State Fiscal Year 2020, September 2019-June 2020.

The proposed change in program start date, to a later date, was necessary to provide Governor and Executive Council sufficient time to review the new contracts, hold two informational hearings, and to allow the Department and the MCOs the needed time for readiness to occur for the new Agreements. These three (3) MCOs will serve approximately 180,000 members including pregnant women, children, parents/caretakers, non-elderly, non-disabled adults under the age of 65, and individuals who are aged, blind or disabled, among others, as described in the Medicaid Care Management (MCM) contracts. The MCOs will cover the acute care, behavioral health, and pharmacy services for all Members and work with the Department to address the crucial social determinants of health in accordance with the attached MCM contracts.

The MCOs will provide a person-centered, integrated, and comprehensive delivery system that offers a very substantial array of accessible Medicaid services, taking into account each Member's physical well-being, behavioral health (mental health and substance use disorders), and social circumstances. The Department will challenge its MCO partners to work responsively with the provider community and MCM Members to improve access to care and promote healthy behaviors. New Hampshire's MCM program will incentivize value over volume, enhance program efficiency, and hold MCOs accountable for demonstrable improvements in health outcomes.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Table One represents a ten-month year capitation rate for the Standard Medicaid and the NH Granite Advantage Health Care Program for the period September 2019 through June 2020 with a comparison to the SFY 2020 rates in the February 15, 2019 signed contracts approved by the Governor and Executive Council of March 27, 2019 (Tabled, 2/20/2019 Late item #A). This allows alignment with State of New Hampshire fiscal year through SFY 2024. The change to the completion date of August 31 2024 is requested to allow for the full 60-month contract that was specified in the request for proposals.

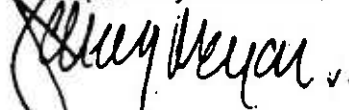
Table 1			
New Hampshire Department of Health and Human Services			
Medicaid Care Management Program			
Comparison of SFY 2020 to September 2019 to June 2020 Capitation Rates			
Based on Projected Enrollment by Rate Cell			
Population	SFY 2020 Capitation Rates	September 2019 to June 2020 Capitation Rates	Percentage Change
Standard Medicaid			
Base Population	\$315.15	\$316.28	0.4%
CHIP*	196.71	197.36	0.3%
Behavioral Health Population	1,386.51	1,387.60	0.1%
Total Standard Medicaid	\$389.03	\$390.19	0.3%
Granite Advantage Health Care Program			
Medically Frail	\$1,025.07	\$1,028.86	0.4%
Non-Medically Frail	482.80	486.09	0.7%
Total GAHCP	\$586.30	\$590.15	0.7%
Total	\$444.28	\$446.21	0.4%

*The CHIP capitation rate is an average of the specific rate cells in which CHIP members are enrolled. We do not develop a CHIP specific capitation rate.

Area served: Statewide. Source of Funds: Funds for Granite Advantage Health Program are 93% Federal as appropriated by Congress and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 78.8% Federal as appropriated by Congress and 21.2% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 24.3% General and 24.7% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, consistent with RSA 126-AA:3, no state general funds shall be deposited into the fund and medical services for this population would end consistent with RSA 126-AA:3,VI and the terms and conditions of the federal waiver issued by the Centers for Medicare and Medicaid Services.

Respectfully submitted,



Jeffrey A. Meyers
Commissioner



Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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February 15, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to enter into Agreements with, AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schraffts City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, in an amount, for State Fiscal Year 2020 shared by all vendors, not to exceed \$924,150,000, effective upon Governor and Executive Council approval, with providing services to members on July 1, 2019 through the completion date of June 30, 2024.

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 79.4% Federal and 20.6% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 24.3% General and 24.7% Other funds.

Funds are anticipated to be available in the following account(s) for State Fiscal Years (SFY) 2020 through 2024 upon the availability and continued appropriation of funds in the future operating budgets. The Centers for Medicare and Medicaid Services (CMS) requires that managed care rate certifications must be done on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each state fiscal year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how this contract aligns with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for SFY 2020.

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: OFC MEDICAID SERVICES, GRANIT ADVANTAGE HEALTH PROGRAM
TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$360,150,000
SFY 2021	101-500729	Medical Payments to Providers	TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD
		Sub-Total:	\$360,150,000

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**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: OFC MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$59,700,000
SFY 2021	101-500729	Medical Payments to Providers	TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD
		<i>Sub-Total:</i>	\$59,700,000

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$504,300,000
SFY 2021	101-500729	Medical Payments to Providers	TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD
		<i>Sub-Total:</i>	\$504,300,000
		Grand Total:	\$924,150,000

EXPLANATION

The purpose of this request is to enter into capitated, risk-based Agreements to provide acute care and other medical services to eligible and enrolled Medicaid participants New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management. ~~These three (3) Vendors will serve approximately 180,000 members including pregnant women, children, parents/caretakers, non-elderly, non-disabled adults under the age of 65, and individuals who are aged, blind or disabled, among others, as described in the Medicaid Care Management (MCM) contracts.~~ The Managed Care Organizations (MCOs) will cover the acute care, behavioral health, and pharmacy services for all Members and work with the Department of Health and Human Services (DHHS) to address the crucial social determinants of health in accordance with the attached MCM contracts.

The MCO Vendors will provide a person-centered, integrated, and comprehensive delivery system that offers a very substantial array of accessible Medicaid services, taking into account each Member's physical well-being, behavioral health (mental health and substance use disorders), and social circumstances. DHHS will challenge its MCO partners to work responsively with the provider community and MCM Members to improve access to care and promote healthy behaviors. New Hampshire's MCM program will incentivize value over volume, enhance program efficiency, and hold MCOs accountable for demonstrable improvements in health outcomes.

Two of the Vendors, Boston Medical Center Health Plan Inc., and Granite State Health Plan Inc., are respectively otherwise known as Well Sense Health Plan, and New Hampshire Healthy Families. The Department presently contracts with both of these Vendors to provide New Hampshire's Medicaid Care Management program.

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I. Procurement Process

These contracts represent the culmination of the Department's first re-procurement of the MCM program since its commencement in December 2013. The Department's process for the development of the program reflected in the contracts and the contracts themselves represent a significant improvement over the prior procurement process and the program itself. The Department -- for the first time ever -- put out the Request for Proposals for public comment and held public information sessions in each of the Executive Council Districts last July in Concord, Keene, Manchester, Nashua, Littleton and Portsmouth before it was issued to potential respondents.

These three (3) Vendors were selected through a competitive bid process. A Request for Proposals RFP-2019-OMS-MANAG-02 was posted on the Department of Health and Human Services' web site from August 30, 2018 through October 31, 2018. A mandatory bidder's conference was held on September 7, 2018. In-person attendance at the Mandatory Bidder's Conference was a requirement to submit a proposal. The Department received four (4) proposals. The proposals were reviewed and scored by a team of individuals with program specific knowledge. The Bid Summary is attached.

II. Central Features of the New MCM Program

This procurement was also focused on improving the program for beneficiaries and providers and introducing many new features. The goals of the new MCM program are to

- Improve care of Members
- Improve health outcomes
- Reduce inpatient hospitalization and re-admissions
- Improve continuity of care across the full continuum of care
- Improve transition planning when care is completed
- Improve medication management
- Reduce unnecessary emergency services
- Decrease the total cost of care
- Increase member satisfaction
- Improve provider participation in the program

In order to help achieve these goals, the new contracts make many changes in the current program. These include the following:

- **Additional Care Coordination and Care Management** resources to provide significantly more beneficiary support to those in greater need, including providing it at a local level. MCOs must provide Care Management for at least 15% of high-risk/high-need members, and MCOs must conduct local care management or contract with a designated care management entity for at least 50% of high-risk/high-need members.
- **Behavioral Health (Mental Health and Substance Use Disorder)** provisions support integration of care with physical health, implementation of the Department's new 10-year Mental Health Plan, and advance SUD treatment. MCOs are required to take into account each person's physical health, behavioral health (mental health and substance use disorders), and social and economic needs. MCOs are required to work with Members, Providers, integrated delivery networks (IDNs), and community mental health

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programs (CMHPs) to integrate physical health and behavioral health and address social determinants of health that affect health outcomes and the cost-effectiveness of care.

- **Emergency Room Waiting Measures** include the provision of additional clinical staff to support the provision of services in hospital emergency departments to reduce the need for Members to wait for inpatient services.
- **Support the Community Mental Health Centers and Substance Use Disorder Providers** by entering into capitated payment arrangements with Community Mental Health Programs and Providers, and reimburse substance use disorder providers at rates no less than the DHHS fee-for-service rates. MCOs must also contract with any willing peer recovery provider.
- **Alternative Payment Models (APMs)** provisions require MCOs to incentivize value over volume and significantly reduce current fee for service billing arrangements.
- **Community Engagement** specifies a role for the MCOs to support beneficiaries in fulfilling the Community Engagement requirement, including assisting their members with understanding qualifying activities and exemptions.
- **New Provider Supports** require MCOs to implement prompt and accessible credentialing and re-credentialing processes that will be used to conduct provider outreach and support; standardize work processes to ensure efficient implementation of the program and minimal provider burden relative to claims billing processes, reporting, and prior authorizations; meet prompt payment requirements and pay claims based on the effective date of the Current Procedural Terminology code, and establish a provider grievance and appeals process.

- **Pharmacy Counselling and Management** are strengthened to help improve the safety and therapeutic benefits to beneficiaries and the economy of the program.
- **Beneficiary Choice and Competition** is increased by providing Medicaid beneficiaries with three high-quality MCOs from which to choose.

- **Incentives and opportunities for beneficiaries to participate in healthy behaviors** must be provided by MCOs to improve individual health.
- **Cost transparency** through reference based pricing and incentives to beneficiaries.
- **Accountability for results** is increasing because a share of payment to MCOs will be directly linked to their performance, ensuring accountability for results, particularly in high priority areas such as addressing substance use disorders, integrating physical and behavioral health, providing robust care management, and reducing unnecessary use of high-cost services.
- **Public Reporting** is an added contract element. Each selected MCO will be responsible for submitting an annual report to the Governor and the legislature reporting on how the MCO has addressed State priorities for the MCM Program, including those specified in RSA 126-AA and in other State statute, policies, and guidelines; what innovative programs it has established; how it is addressing social determinants of health of its members, and how it is improving the population health of the state and other key metrics of the program.
- **Heighten program compliance and integrity provisions** have been added that allow for liquidated damages to be applied to the MCOs around contractual performance; provisions that incent MCO performance around collections for third party liability and coordination of benefits; and general fraud waste and abuse.

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- **Medical Loss Ratio** is specified in the contract at a minimum amount of 85% that must be spent on service delivery to beneficiaries, any amount less is to be rebated back to the Program.

III. Rate-making and Budget

The Department's actuary, Milliman, has certified a rate that is actuarially sound for this program. These rates are reflected in Table I below:

Table I New Hampshire Department of Health and Human Services SFY 2020 Capitation Rate Change Based on Projected SFY 2020 MCO Enrollment by Rate Cell			
Population	January 2019 to June 2019 Capitation Rate	SFY 2020 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$303.54	\$315.15	3.8%
CHIP*	188.36	196.71	4.4%
Behavioral Health Population	1,294.03	1,386.51	7.1%
Total Standard Medicaid	\$371.26	\$389.03	4.8%
Granite Advantage Health Care Program			
Medically Frail	\$993.36	\$1,025.07	3.2%
Non-Medically Frail	423.21	482.80	14.1%
Total GAHCP	\$532.03	\$586.30	10.2%
Total	\$416.29	\$444.28	6.7%

*The CHIP capitation rate is an average of the specific rate cells in which CHIP members are enrolled. We do not develop a CHIP specific capitation rate.

Federal law requires that managed care rates be reviewed no less frequently than a 12-month period. The Department aligns this process with the state fiscal year. Over the last several years, the rates have been reviewed and an amendment made to the MCM contracts in May or June for the fiscal year beginning on July 1st. In order to maintain actuarial soundness, the rates are also required to be reviewed in the event of significant program changes. For example, while the Department established rates for FY 2019 last spring, the Department was required to refresh and update the rates when the Medicaid expansion program was brought back into managed care on January 1, 2019 – in the middle of the state fiscal year.

This year, there are items in both the Governor's budget and in other legislation now pending that, if and when enacted, would require Milliman to revise the rates. Specifically, there are proposals to (i) raise the rates paid to community based designated receiving facilities, (ii) add transitional housing for persons who can be discharged from New Hampshire Hospital; (iii) add mobile crisis teams or other behavioral health crisis services. All of these

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additional services will have to be incorporated into the capitated rates for the managed care program consistent with their effective dates.

As a result, the Department anticipates that following the end of the legislative session, Milliman will review all program changes and any other relevant information, and adjust the rates as necessary. The Department would expect to bring an amendment to the contract in the September or October time frame for this purpose.

The certified rate established for the program that is reflected in this contract is within the Department's budget for state fiscal year 2020. Even though that the rates have been increased, a decline in the number of persons enrolled in Medicaid and a decline in the acuity of the population that has reduced expenditures in certain of the highest rate cells accounts for a reduction of total expenditure in the program within the current budget. As we have in the past, the Department and Milliman will work with the legislature in the budget process to ensure that the program is funded consistent with the budget.

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 93% Federal as appropriated by Congress and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 79.4% Federal as appropriated by Congress and 20.6% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 24.3% General and 24.7% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, consistent with RSA 126-AA:3, no state general funds shall be deposited into the fund and medical services for this population would end consistent with RSA 126-AA:3, VI and the terms and conditions of the federal waiver issued by the Centers for Medicare and Medicaid Services

Respectfully submitted,


Jeffrey A. Meyers
Commissioner

**State of New Hampshire
Department of Health and Human Services
Amendment #10 to the Medicaid Care Management Services Contract**

This 10th Amendment to the Medicaid Care Management Services contract (hereinafter referred to as "Amendment #10") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Granite State Health Plan Inc.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on March 27, 2019, (Tabled Late Item A), as amended on April 17, 2019 (Item #9), as amended on December 18, 2019 (Item #15), as amended on May 20, 2020 (Item #7A), as amended on June 10, 2020 (Item #6), as amended on January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), as amended on December 08, 2021 (Item #6-1), as amended on June 15, 2022 (Item # Tabled Item 20A), and as amended on December 21, 2022 (Item #13A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to modify the price limitation and modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify Form P-37, General Provisions, Block 1.8, Price Limitation, to read: \$5,928,058,454
2. Modify Exhibit A, Amendment #9 by replacing it in its entirety with Exhibit A, Amendment #10, which is attached hereto and incorporated by reference herein. Modifications to Exhibit A, Amendment #9 are outlined below:
 - a. Modify Exhibit A, Section 2.1.53.2, to read:

2.1.53.2. A Member cannot be required by the MCO to use the alternative service or setting. Beginning January 3, 2023, all In Lieu Of Services shall be reviewed for consideration and authorization in accordance with federal regulations, as appropriate. [42 CFR 438.3(e)(2)(i) - (iii); SMDL #23-001]
 - b. Modify Exhibit A, Section 3.13.1.1, to read:

3.13.1.1 The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.13 (Compliance with State and Federal Laws), and any laws, regulations or administrative rules effective after the execution of this Agreement. The MCO shall comply with any applicable federal and State laws that pertain to Member rights and ensure that its employees and Participating Providers observe and protect those rights. [42 CFR 438.100(a)(2)]
 - c. Modify Exhibit A, Section 3.13.1.3, to read:

3.13.1.3 The MCO shall comply with all aspects of the DHHS Sentinel Event Reporting and Review Policy PO.1003, and any subsequent versions and/or amendments;
 - d. Modify Exhibit A, Section 3.13.1.3.1, to read:

3.13.1.3.1 The MCO shall 1) cooperate with review of any reported sentinel event, and provide any additional reporting information requested by DHHS, and 2) participate in a DHHS sentinel

event review, if requested;

- e. Modify Exhibit A, Section 3.15.1.3.1.3, to read:
3.15.1.3.1.3 For the period January 1, 2021 through August 31, 2024, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions.
- f. Modify Exhibit A, Section 3.15.1.3.2.3, to read:
3.15.1.3.2.3 For the period January 1, 2021 through August 31, 2024, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions
- g. Modify Exhibit A, Section 3.15.1.3.5.2, to read:
3.15.1.3.5.2 For the period January 1, 2021 through August 31, 2024, the Long Term Care Coordinator position is not required.
- h. Modify Exhibit A, Section 3.15.1.3.8.7, to read:
3.15.1.3.8.7 For the period January 1, 2021 through August 31, 2024, the Housing Coordinator position is not required.
- i. Modify Exhibit A, Section 3.15.2.2.3.1, to read:
3.15.2.2.3.1 For the period January 1, 2021 through August 31, 2024, the Psychiatric Boarding program's hospital-credentialed Provider position(s) are not required.
- j. Modify Exhibit A, Section 3.15.2.3.1, to read:
3.15.2.3.1 For the period January 1, 2021 through August 31, 2024, the Staff for Members at New Hampshire Hospital position is not required.
- k. Modify Exhibit A, Section 3.15.2.4.5, to read:
3.15.2.4.5 For the period January 1, 2021 through August 31, 2024, the Behavioral Health Staff position responsible for in-person housing assistance is not required.
- l. Modify Exhibit A, Section 4.1.2, Covered Services Table, by adding Footnote #9, to read:
9 For the period July 1, 2021 through August 31, 2024, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.
- m. Modify Exhibit A, Section 4.1.2, Covered Services Table, by adding Footnote #10, to read:
10 Effective April 1, 2023, certain preventive, restorative, denture and other oral health services are carved-out of the MCM Program and covered under the State's contract with Delta Dental of New Hampshire, Inc. for eligible adults ages 21 years and over. Dental and oral health emergency services for Medicaid enrolled children and adults of all ages will continue to be Covered Services under the MCM Program.
- n. Modify Exhibit A, Section 4.1.3.5.1, to read:
4.1.3.5.1 The MCO may provide Members with services or settings that are "In Lieu Of" Services or settings with prior approval and in accordance with federal regulations.
- o. Modify Exhibit A, Section 4.1.3.5.1.1, to read:
4.1.3.5.1.1 Intentionally left blank.
- p. Modify Exhibit A, Section 4.1.3.5.1.2, to read:
4.1.3.5.1.2 Intentionally left blank.

- q. Modify Exhibit A, Section 4.1.3.5.1.3, to read:
4.1.3.5.1.3 Intentionally left blank.
- r. Modify Exhibit A, Section 4.1.3.5.1.4, to read:
4.1.3.5.1.4 Intentionally left blank.
- s. Add Exhibit A, Section 4.1.3.5.1.5, to read:
4.1.3.5.1.5 Any In Lieu of Services on record prior to January 3, 2023 and proposed for continuation must comply with CMS federal regulations beginning January 1, 2024. [42 CFR 438.3(e)(2)(i) - (iii); SMDL 1/4/23]
- t. Modify Exhibit A, Section 4.1.3.5.2, to read:
4.1.3.5.2 Intentionally left blank.
- u. Modify Exhibit A, Section 4.1.3.5.3, to read:
4.1.3.5.3 Beginning September 1, 2019, DHHS has authorized medical nutrition, diabetes self-management, and assistance in finding and keeping housing (not including rent), as In Lieu Of Services. This list may be expanded upon or otherwise modified by DHHS through amendments of this Agreement. Previously authorized In Lieu Of Services are scheduled for review and modification as may be necessary to meet federal regulatory compliance effective January 1, 2024.
- v. Modify Exhibit A, Section 4.1.3.5.4, to read:
4.1.3.5.4 Intentionally left blank.
- w. Modify Exhibit A, Section 4.1.3.5.5, to read:
4.1.3.5.5 The MCO shall support In Lieu of Services reporting, in accordance with federal regulations and Exhibit O.
- x. Modify Exhibit A, Section 4.1.9.1.1, to read:
4.1.9.1.1 The MCO shall assume medical necessity for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility.
- y. Modify Exhibit A, Section 4.3.6.2.2, to add:

Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)					
Distribution for Period Ending	Health Risk Assessment Completion	Encounter, Data Timeliness Completeness and Quality	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Total Possible Members Awarded by Period
9/30/2023	2,000			1,000	3,000
12/31/2023	2,000		1,000		3,000
3/31/2024		1,000	1,000	1,000	3,000
6/30/2024		3,000			3,000
8/31/2024			2,000		2,000

- z. Modify Exhibit A, Section 4.4.1.4.4.3.3 (8) to read:
(8) The cultural and linguistic capabilities of Participating Providers; including languages (including American Sign Language (ASL)) offered by the Provider or a skilled medical interpreter at the Provider's office;

- aa. Modify Exhibit A, Section 4.5.3.8, to read:
 - 4.5.3.8 The MCO shall provide the Member and the Member's representative an opportunity to receive the Member's case file, free of charge prior and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b) - (c)]
- bb. Modify Exhibit A, Section 4.10.8.1.1, to read:
 - 4.10.8.1.1 As described in this Section 4.10.8, Local Care Management is optional for the period January 1, 2021 through August 31, 2024.
- cc. Modify Exhibit A, Section 4.10.8.1.1.1, to read:
 - 4.10.8.1.1.1 For the period July 1, 2021 through August 31, 2024, the term "Local Care Management" shall also mean "Care Management" in this Section 4.10.8.
- dd. Modify Exhibit A, Section 4.11.2.2.1, to read:
 - 4.11.2.2.1 For the period July 1, 2021 through August 31, 2024, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.
- ee. Modify Exhibit A, Section 4.11.5.7.2.1, to read:
 - 4.11.5.7.2.1 For the period January 1, 2021 through August 31, 2024, the Housing Coordinator position is not required.
- ff. Modify Exhibit A, Section 4.11.5.17.1.1., to read:
 - 4.11.5.17.1.1. For the period January 1, 2021 through August 31, 2024, the Psychiatric Boarding program's hospital-credentialed Provider position(s) described in Sections 4.11.5.17.1 through 4.11.5.17.4, and 4.11.5.17.6 are not required.
- gg. Modify Exhibit A, Section 4.15.5.4.1, to read:
 - 4.15.5.4.1 The MCO shall limit any MOE clawback that is determined to fifty percent (50%) for the period July 1, 2023 through August 31, 2024; and limit MOE clawback to seventy percent (70%) for the period January 1, 2023 through June 30, 2023.
- hh. Modify Exhibit A, Section 4.15.5.5.4, to read:
 - 4.15.5.5.4 For the rating period July 1, 2023 through August 31, 2024, directed payment amounts determined by DHHS shall comprise a fee schedule adjustment or uniform dollar increase for assertive community treatment, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, consistent illness management and recovery services, and step down community residence beds for individuals dually diagnosed with serious mental illness and developmental disabilities, within the Community Mental Health Programs class of network providers as approved by CMS, including any alternate CMS-approved directed payment methodology.
- ii. Modify Exhibit A, Section 4.15.5.6.2, to read:
 - 4.15.5.6.2 For the rating period July 1, 2023 through August 31, 2024, directed payment remittance shall comprise a minimum fee schedule at least at the FFS rates established by DHHS for Community Residential Services.
- jj. Modify Exhibit A, Section 4.15.10, by adding Subsection 4.15.10.1.5, to read:
 - 4.15.10.1.5 For the rating period July 1, 2023 through August 31, 2024, MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan

fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

kk. Modify Exhibit A, Section 4.15.13, Subsection 4.15.13.1, by adding Subsection 4.15.13.1.4, to read:

4.15.13.1.4 For the rating period July 1, 2023 through August 31, 2024, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology. Qualified directed payments are tied to actual hospital services, including the number of inpatient discharges and outpatient visits reported by qualifying Providers.

ll. Modify Exhibit A, Section 4.15.14, Subsection 4.15.14.1, by adding Subsection 4.15.14.1.3, to read:

4.15.14.1.3 For the July 1, 2023 through August 31, 2024 rating period, the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 State Plan DRG fee schedule payment amounts described in Section 6.2.41.1.

mm. Modify Exhibit A, Section 4.15.15, Subsection 4.15.15.1, by adding Subsection 4.15.15.1.3, to read:

4.15.15.1.3 For the rating period July 1, 2023 through August 31, 2024, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

nn. Modify Exhibit A, Section 4.15.16.1, to read:

4.15.16.1 The MCO shall reimburse inpatient psychiatric services delivered in state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

oo. Modify Exhibit A, Section 4.15.16.1.2, to read:

4.15.16.1.2 For the rating period July 1, 2023 through August 31, 2024, the facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

pp. Modify Exhibit A, Section 4.15.16, by adding Subsection 4.15.16.2, to read:

4.15.16.2 The MCO shall reimburse inpatient psychiatric professional services delivered in the state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

qq. Modify Exhibit A, Section 4.15.16, by adding Subsection 4.15.16.2.1, to read:

4.15.16.2.1 For the rating period July 1, 2023 through August 31, 2024, directed payment amounts shall comprise minimum fee schedule payments at no less than the Medicare rates for inpatient psychiatric professional services delivered in the state-owned facilities.

rr. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.17, to read:

4.15.17 Payment Standard for Birthing Centers

ss. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.17.1, to read:

4.15.17.1 For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services at no less than NH Medicaid fee schedule rates.

- tt. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.18, to read:
 - 4.15.18 Qualifying Children's Hospitals
 - uu. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.18.1, to read:
 - 4.15.18.1 The MCO shall remit directed payments to qualifying Children's Hospitals substantively serving NH Medicaid Members, in accordance with separate guidance, as follows:
 - vv. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.18.2, to read:
 - 4.15.18.2 For the rating period July 1, 2023 through August 31, 2024, a directed payment add-on amount in addition to the MCO's negotiated rate shall be awarded to qualifying Children's Hospitals for each eligible inpatient and outpatient hospital service encounter as approved by CMS.
 - ww. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.19, to read:
 - 4.15.19 Payment Standard for Ambulance Services
 - xx. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.19.1, to read:
 - 4.15.19.1 For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Providers for all ambulance and chair car Covered Services at no less than NH Medicaid fee schedule rates.
 - yy. Modify Exhibit A, Section 5.3.7.3, to read:
 - 5.3.7.3 The MCO and the MCO's Providers and Subcontractors shall permit DHHS, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises at any time to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours.
 - zz. Modify Exhibit A, Section 5.4.5.1.2, by adding Section 5.4.5.1.2.1, to read:
 - 5.4.5.1.2.1 The MCO shall be eligible for a maximum withhold capitation credit for the July 1, 2023 through August 31, 2024 rating period up to 0.15% based on Members who have completed their redeterminations between July 1, 2023 through October 31, 2023 as described in the MCM Withhold and Incentive Guidance.
 - aaa. Modify Exhibit A, Section 5.4.5, by adding Section 5.4.5.2, to read:
 - 5.4.5.2 The MCO may be eligible for additional monetary incentives from the unearned withhold funds related to performance of activities to enhance care management and administrative practices including, but not limited to: fraud, waste, and abuse; medication reviews; polypharmacy; substance use disorder; and opioid treatment provider oversight and compliance as described in separate guidance.
 - bbb. Modify Exhibit A, Section 6.2.12.1, to read:
 - 6.2.12.1 The September 2019 to August 31, 2024 capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.
 - ccc. Modify Exhibit A, Section 6.2.12., by adding Section 6.2.12.3, to read:
 - 6.2.12.3 For the rating period July 1, 2023 through August 31, 2024 capitation rates include a preliminary acuity adjustment based on DHHS's intended PHE unwind process and a detailed redetermination schedule to estimate the percentage of Members expected to leave the Medicaid program for each redetermination cohort as explained in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid

Services for this rating period Amendment. The adjustment will be updated for Amendment #11 capitation rates, as appropriate.

ddd. Modify Exhibit A, Section 6.2.36.1, by adding Subsection 6.2.36.1.4, to read:

6.2.36.1.4 For the period July 1, 2023 through August 31, 2024, the attachment point shall be \$740,000.

eee. Modify Exhibit A, Section 6.2.38.2, to read:

6.2.38.2 For the contract period July 1, 2023 through August 31, 2024, the cost of the COVID-19 vaccines and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

fff. Modify Exhibit A, Section 6.2.41, to read:

6.2.41 For the July 1, 2023 through August 31, 2024 rating period, DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG codes 880-887, except as described in Section 6.2.41.3 below.

ggg. Modify Exhibit A, Section 6.3.4.1, to read:

6.3.4.1 For the period July 1, 2023 through August 31, 2024, the target MLR for at-risk services is 90.8% for Standard Medicaid and 89.9% for GAHCP based on the projected enrollment distribution for the rating period. Please note, each program's target MLR may change in future rate amendments as a result of changes to underlying assumptions, such as enrollment projections, emerging utilization experience, and the retroactive acuity adjustments, if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

hhh. Modify Exhibit A, Section 6.3.4.1.1, to read:

6.3.4.1.1 The minimum MLR is set on a program-wide basis for each major population, such that the maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). The minimum MLR shall be 88.3% for the Standard Medicaid population and 87.4% for the GAHCP population.

iii. Modify Exhibit A, Section 6.3.4.1.2, to read:

6.3.4.1.2 The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCOs will have a maximum loss of 2.0%. Based on the target MLRs, the maximum MLR shall be 94.3% for the Standard Medicaid population and 93.4% for the GAHCP population.

3. Modify Exhibit B, Amendment #9 by replacing it in its entirety with Exhibit B, Amendment #10, which is attached hereto and incorporated by reference herein.
4. Modify Exhibit O, Amendment #9 by replacing it in its entirety with Exhibit O, Amendment #10, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment remain in full force and effect. This Amendment shall be effective July 1, 2023, subject to Governor and Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

5/30/2023

Date

DocuSigned by:
Henry D. Lipman

Name: Henry D. Lipman
Title: Medicaid Director

Granite State Health Plan Inc.

5/30/2023

Date

DocuSigned by:
Clyde White

Name: Clyde white
Title: president & CEO

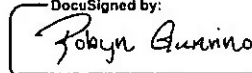
The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

5/30/2023

Date

DocuSigned by:



Name: Robyn Guarino

Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:

Title:



Medicaid Care Management
Services Contract

EXHIBIT A – AMENDMENT #10

SCOPE OF SERVICES

Medicaid Care Management Services Contract



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1 INTRODUCTION

1.1 Purpose

1.1.1 This Medicaid Care Management Agreement is a comprehensive full risk prepaid capitated Agreement that sets forth the terms and conditions for the Managed Care Organization's (MCO's) participation in the New Hampshire (NH) Medicaid Care Management (MCM) program.

1.1.2 ~~[Amendment #1:] All terms and conditions of the Agreement not inconsistent with this Agreement #1 remain in full force and effect.~~

1.2 Term

1.2.1 The Agreement and all contractual obligations, including Readiness Review, shall become effective on the date the Governor and Executive Council approves the executed MCM Agreement or, if the MCO does not have health maintenance organization (HMO) licensure in the State of New Hampshire on the date of Governor and Executive Council approval, the date the MCO obtains HMO licensure in the State of New Hampshire, whichever is later.

1.2.1.1 If the MCO fails to obtain HMO licensure within thirty (30) calendar days of Governor and Executive Council approval, this Agreement shall become null and void without further recourse to the MCO.

1.2.2 [Amendment #1:] The Program Start Date shall begin September 1, 2019, and the Agreement term shall continue through August 31, 2024.

~~[Base Contract:] The Program Start Date shall begin on July 1, 2019, and the Agreement term shall continue through June 30, 2024.~~

1.2.3 The MCO's participation in the MCM program is contingent upon approval by the Governor and Executive Council, the MCO's successful completion of the Readiness Review process as determined by DHHS, and obtaining HMO licensure in the State of New Hampshire as set forth above.

1.2.4 The MCO is solely responsible for the cost of all work during the Readiness Review and undertakes the work at its sole risk.

1.2.5 [Amendment #1:] If DHHS determines that any MCO will not be ready to begin providing services on the MCM Program Start Date, September 1, 2019, at its sole discretion, DHHS may withhold enrollment and require corrective action or terminate the Agreement without further recourse to the MCO.

~~[Base Contract:] If DHHS determines that any MCO will not be ready to begin providing services on the MCM Program Start Date, July 1, 2019, at its sole discretion, DHHS may withhold enrollment and require corrective action or terminate the Agreement without further recourse to the MCO.~~

Medicaid Care Management Services Contract

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2 DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.1 **Adults with Special Health Care Needs**

2.1.1.1 "Adults with Special Health Care Needs" means Members who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age.

2.1.1.1.1 This includes, but is not limited to Members with: Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); a Severe Mental Illness (SMI), Serious Emotional Disturbance (SED), Intellectual and/or Developmental Disability (I/DD), Substance Use Disorder diagnosis; or chronic pain.

2.1.2 **Advance Directive**

2.1.2.1 "Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of New Hampshire, relating to the provision of health care when a Member is incapacitated. [42 CFR 489.100]

2.1.3 **Affordable Care Act**

2.1.3.1 "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted on March 30, 2010.

2.1.4 **Agreement**

2.1.4.1 "Agreement" means this entire written Agreement between DHHS and the MCO, including its exhibits.

2.1.5 **American Society of Addiction Medicine (ASAM) Criteria**

2.1.5.1 "American Society of Addiction Medicine (ASAM) Criteria" means a national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. The Criteria provides guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.¹

¹ The American Society of Addiction Medicine, "What is the ASAM Criteria"

Medicaid Care Management Services Contract

New Hampshire Department of Health and Human Services
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2.1.6 Americans with Disabilities Act (ADA)

2.1.6.1 "Americans with Disabilities Act (ADA)" means a civil rights law that prohibits discrimination against Members with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.²

2.1.7 Appeal Process

2.1.7.1 "Appeal Process" means the procedure for handling, processing, collecting and tracking Member requests for a review of an adverse benefit determination which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.8 Area Agency

2.1.8.1 "Area Agency" means an entity established as a nonprofit corporation in the State of New Hampshire which is established by rules adopted by the Commissioner to provide services to developmentally disabled persons in the area as defined in RSA 171-A:2.

2.1.9 ASAM Level of Care

2.1.9.1 "ASAM Level of Care" means a standard nomenclature for describing the continuum of recovery-oriented addiction services. With the continuum, clinicians are able to conduct multidimensional assessments that explore individual risks and needs, and recommended ASAM Level of Care that matches intensity of treatment services to identified patient needs.

2.1.10 Assertive Community Treatment (ACT)

2.1.10.1 "Assertive Community Treatment (ACT)" means the evidence-based practice of delivering comprehensive and effective services to Members with SMI by a multidisciplinary team primarily in Member homes, communities, and other natural environments.

2.1.11 Auxiliary Aids

2.1.11.1 "Auxiliary Aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy, the benefits of programs or activities conducted by the MCO.

2.1.11.1.1 Such aids include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible

² The Americans with Disability Act National Network, "What is the Americans with Disabilities Act"

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with hearing aids, telecommunication devices for deaf persons (TDDs), interpreters, note takers, written materials, and other similar services and devices.

2.1.12 Behavioral Health Services

2.1.12.1 "Behavioral Health Services" means mental health and Substance Use Disorder services that are Covered Services under this Agreement.

2.1.13 [Amendment #7:] Intentionally Left Blank Behavioral Health Crisis Treatment Center (BHCTC)

~~2.1.13.1 [Amendment #7:] "Behavioral Health Crisis Treatment Center (BHCTC)" means a treatment service center that provides twenty-four (24) hours a day, seven (7) days a week intensive, short term stabilization treatment services for Members experiencing a mental health crisis, including those with co-occurring Substance Use Disorder.~~

~~2.1.13.2 [Amendment #7:] The BHCTC accepts Members for treatment on a voluntary basis who walk in, are transported by first responders, or as a stepdown treatment site post emergency department (ED) visit or inpatient psychiatric treatment site.~~

~~2.1.13.3 [Amendment #7:] The BHCTC delivers an array of services to de-escalate and stabilize Members at the intensity and for the duration necessary to quickly and successfully discharge, via specific after care plans, the Member back into the community or to a step-down treatment site.~~

2.1.14 Bright Futures

2.1.14.1 "Bright Futures" means a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) that provides theory-based and evidence-driven guidance for all preventive care screenings and well-child visits.

2.1.15 Capitation Payment

2.1.15.1 "Capitation Payment" means the monthly payment by DHHS to the MCO for each Member enrolled in the MCO's plan for which the MCO provides Covered Services under this Agreement.

2.1.15.1.1 Capitation payments are made only for Medicaid-eligible Members and retained by the MCO for those Members. DHHS makes the payment regardless of whether the Member receives services during the period covered by the payment. [42 CFR 438.2]

2.1.16 Care Coordination

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2.1.16.1 [Amendment #2:] "Care Coordination" means the interaction with established local community-based providers of care, including Local Care Management Networks entities, to address the physical, behavioral health and psychosocial needs of Members.

2.1.17 Care Management

2.1.17.1 "Care Management" means direct contact with a Member focused on the provision of various aspects of the Member's physical, behavioral health and needed supports that will enable the Member to achieve the best health outcomes.

2.1.18 Care Manager

2.1.18.1 [Amendment #2:] "Care Manager" means a qualified and trained individual who is hired directly by the MCO, a provider in the MCO's network (a "Participating Provider"), or a provider for a Local Care Management Network entity with which the MCO contracts who is primarily responsible for providing Care Coordination and Care Management services as defined by this Agreement.

2.1.19 Case Management

2.1.19.1 "Case Management" means services that assist Members in gaining access to needed waivers and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

2.1.20 Centers for Medicare & Medicaid Services (CMS)

2.1.20.1 "Centers for Medicare & Medicaid Services (CMS)" means the federal agency within the United States Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare programs.

2.1.21 Children with Special Health Care Needs

2.1.21.1 "Children with Special Health Care Needs" means Members under age twenty-one (21) who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age.

2.1.21.1.1 This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with Neonatal Abstinence Syndrome (NAS); in high stress social environments/caregiver stress; receiving Family Centered Early

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Supports and Services, or participating in Special Medical Services or Partners in Health Services with a SED, I/DD or Substance Use Disorder diagnosis.

2.1.22 Children's Health Insurance Program (CHIP)

2.1.22.1 "Children's Health Insurance Program (CHIP)" means a program to provide health coverage to eligible children under Title XXI of the Social Security Act.

2.1.23 Choices for Independence (CFI)

2.1.23.1 "Choices for Independence (CFI)" means the Home and Community-Based Services (HCBS) 1915(c) waiver program that provides a system of Long Term Services and Supports (LTSS) to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities.

2.1.23.2 The CFI waiver is also known as HCBS for the Elderly and Chronically Ill (HCBS-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and Covered Services are identified in He-E 801.

2.1.24 Chronic Condition

2.1.24.1 "Chronic Condition" means a physical or mental impairment or ailment of indefinite duration or frequent recurrence such as heart disease, stroke, cancer, diabetes, obesity, arthritis, mental illness or a Substance Use Disorder.

2.1.25 Clean Claim

2.1.25.1 ~~[Amendment #7:] [Amendment #6:]~~ "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a health plan's State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. [42 CFR 447.45(b)] ~~"Clean Claim" means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.~~

2.1.26 Cold Call Marketing

2.1.26.1 "Cold Call Marketing" means any unsolicited personal contact by the MCO or its designee, with a potential Member or a

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Member with another contracted MCO for the purposes of Marketing.
[42 CFR 438.104(a)]

2.1.27 Community Mental Health Services

2.1.27.1 "Community Mental Health Services" means mental health services provided by a Community Mental Health Program ("CMH Program") or Community Mental Health Provider ("CMH Provider") to eligible Members as defined under He-M 426.

2.1.28 Community Mental Health Program ("CMH Program")

2.1.28.1 "Community Mental Health Program ("CMH Program")", synonymous with Community Mental Health Center, means a program established and administered by the State of New Hampshire, city, town, or county, or a nonprofit corporation for the purpose of providing mental health services to the residents of the area and which minimally provides emergency, medical or psychiatric screening and evaluation, Case Management, and psychotherapy services, [RSA 135-C:2, IV] A CMH Program is authorized to deliver the comprehensive array of services described in He-M 426 and is designated to cover a region as described in He-M 425.

2.1.29 Community Mental Health Provider ("CMH Provider")

2.1.29.1 "Community Mental Health Provider ("CMH Provider")" means a Medicaid Provider of Community Mental Health Services that has been previously approved by the DHHS Commissioner to provide specific mental health services pursuant to He-M 426 [He-M 426.02: (g)]. The distinction between a CMH Program and a CMH Provider is that a CMH Provider offers a more limited range of services.

2.1.30 Comprehensive Assessment

2.1.30.1 "Comprehensive Assessment" means a person-centered assessment to help identify a Member's health condition, functional status, accessibility needs, strengths and supports, health care goals and other characteristics to inform whether a Member requires Care Management services and the level of services that should be provided.

2.1.31 Confidential Information

2.1.31.1 "Confidential Information" or "Confidential Data" means information that is exempt from disclosure to the public or other unauthorized persons under State or federal law. Confidential Information includes, but is not limited to, personal information (PI). See definition also listed in Exhibit K.

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2.1.32 Consumer Assessment of Health Care Providers and Systems (CAHPS®)

2.1.32.1 "Consumer Assessment of Health Care Providers and Systems (CAHPS®)" means a family of standardized survey instruments, including a Medicaid survey, used to measure Member experience of health care.

2.1.33 Continuity of Care

2.1.33.1 "Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through Member transitions between: facilities and home; facilities; Providers; service areas; managed care contractors; Marketplace, Medicaid fee-for-service (FFS) or private insurance and managed care arrangements. Continuity of Care occurs in a manner that prevents unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

2.1.34 Continuous Quality Improvement (CQI)

2.1.34.1 "Continuous Quality Improvement (CQI)" means the systematic process of identifying, describing, and analyzing strengths and weaknesses and then testing, implementing, learning from, and revising solutions.

2.1.35 Copayment

2.1.35.1 "Copayment" means a monetary amount that a Member pays directly to a Provider at the time a covered service is rendered.

2.1.36 Corrective Action Plan (CAP)

2.1.36.1 "Corrective Action Plan (CAP)" means a plan that the MCO completes and submits to DHHS to identify and respond to any issues and/or errors in instances where it fails to comply with DHHS requirements.

2.1.37 Covered Services

2.1.37.1 "Covered Services" means health care services as defined by DHHS and State and federal regulations and includes Medicaid State Plan services specified in this Agreement, In Lieu of Services, any Value-Added Services agreed to by the MCO in the Agreement, and services required to meet Mental Health Parity and Addiction Equity Act.

2.1.38 Amendment #2: Designated Local Care Management Networks Entities

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[Amendment #2:] "Designated Local Care Management Networks Entities" means Integrated Delivery Networks (IDNs) that have been certified as Designated Local Care Management Networks Entities by DHHS; Health Homes, if DHHS elects to implement Health Homes under the Medicaid State Plan Amendment authority; and other contracted entities capable of performing Local Care Management for a designated cohort of Members, as determined by DHHS.

2.1.39 Designated Receiving Facility

2.1.39.1 "Designated Receiving Facility" means a hospital-based psychiatric unit or a non-hospital-based residential treatment program designated by the Commissioner to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system as defined in He-M 405.

2.1.40 Dual-Eligible Members

2.1.40.1 "Dual-Eligible Members" means Members who are eligible for both Medicare and Medicaid.

2.1.41 Emergency Medical Condition

2.1.41.1 "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the Member (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]

2.1.42 Emergency Services

2.1.42.1 "Emergency Services" means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition. [42 CFR 438.114(a)]

2.1.43 Equal Access

2.1.43.1 "Equal Access" means all Members have the same access to all Providers and services.

2.1.44 Evidence-Based Supported Employment (EBSE)

2.1.44.1 "Evidence-Based Supported Employment (EBSE)" means the provision of vocational supports to Members following the Supported Employment Implementation Resource Kit developed by

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Dartmouth Medical School to promote successful competitive employment in the community.

2.1.45 Exclusion Lists

2.1.45.1 "Exclusion Lists" means HHS Office of the Inspector General's (OIG) List of Excluded Individuals/Entities; the System of Award Management; the Social Security Administration Death Master File; the list maintained by the Office of Foreign Assets Controls; and to the extent applicable, National Plan and Provider Enumeration System (NPPES).

2.1.46 External Quality Review (EQR)

2.1.46.1 "External Quality Review (EQR)" means the analysis and evaluation described in 42 CFR 438.350 by an External Quality Review Organization (EQRO) detailed in 42 CFR 438.42 of aggregated information on quality, timeliness, and access Covered Services that the MCO or its Subcontractors furnish to Medicaid recipients.

2.1.47 Family Planning Services

2.1.47.1 "Family Planning Services" means services available to Members by Participating or Non-Participating Providers without the need for a referral or Prior Authorization that include:

2.1.47.1.1 Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

2.1.47.1.2 Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

2.1.47.1.3 Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

2.1.47.1.4 Referral of Members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

2.1.47.1.5 Immunization services where medically indicated and linked to sexually transmitted diseases, including but not limited to Hepatitis B and Human papillomaviruses vaccine.

2.1.48 Federally Qualified Health Centers (FQHCs)

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2.1.48.1 "Federally Qualified Health Center (FQHC)" means a public or private non-profit health care organization that has been identified by the Health Resources and Services Administration (HRSA) and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.

2.1.49 Granite Advantage Members

2.1.49.1 "Granite Advantage Members" means Members who are covered under the NH Granite Advantage waiver, which includes individuals in the Medicaid new adult eligibility group, covered under Title XIX of the Social Security Act who are adults, aged nineteen (19) up to and including sixty-four (64) years, with incomes up to and including one hundred and thirty-eight percent (138%) of the federal poverty level (FPL) who are not pregnant, not eligible for Medicare and not enrolled in NH's Health Insurance Premium Payment (HIPP) program.

2.1.50 Grievance Process

2.1.50.1 "Grievance Process" means the procedure for addressing Member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.51 Home and Community Based Services (HCBS)

2.1.51.1 "Home and Community Based Services (HCBS)" means the waiver of Sections 1902(a)(10) and 1915(c) of the Social Security Act, which permits the federal Medicaid funding of LTSS in non-institutional settings for Members who reside in the community or in certain community alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility (ICF). This includes services provided under the HCBS-CFI waiver program, Developmental Disabilities (HCBS-DD) waiver program, Acquired Brain Disorders (HCBS-ABD) waiver program, and In Home Supports (HCBS-I) waiver program.

2.1.52 Hospital-Acquired Conditions and Provider Preventable Conditions

2.1.52.1 "Hospital-Acquired Conditions and Provider Preventable Conditions" means a condition that meets the following criteria: Is identified in the Medicaid State Plan; has been found by NH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Member; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a

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Member, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong Member.

2.1.53 In Lieu Of Services

2.1.53.1 An "In Lieu Of Service" means an alternative service or setting that DHHS has approved as medically appropriate and cost-effective substitute for a Covered Service or setting under the Medicaid State Plan.

2.1.53.2 [Amendment #10:] A Member cannot be required by the MCO to use the alternative service or setting. Beginning January 3, 2023, all Any In Lieu Of Services shall be reviewed for consideration and shall be authorized in accordance with federal regulations, as appropriate by DHHS, either via DHHS's issuance of prospective identification of approved In Lieu of Services or through an agreement reached between DHHS and the MCO. [42 CFR 438.3(e)(2)(i) - (iii); SMDL #23-001]

2.1.53.3 The utilization and actual cost of In Lieu Of Services shall be taken into account in developing the component of the capitation rates that represents the Medicaid State Plan Covered Services, unless a statute or regulation explicitly requires otherwise.

2.1.54 Incomplete Claim

2.1.54.1 "Incomplete Claim" means a claim that is denied for the purpose of obtaining additional information from the Provider.

2.1.55 Indian Health Care Provider (IHCP)

2.1.55.1 "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in the Indian Health Care Improvement Act (25 U.S.C. 1603). [42 CFR 438.14(a)]

2.1.56 Integrated Care

2.1.56.1 "Integrated Care" means the systematic coordination of mental health, Substance Use Disorder, and primary care services to effectively care for people with multiple health care needs.³

2.1.57 Integrated Delivery Network (IDN)

2.1.57.1 "Integrated Delivery Network" means a regionally-based network of physical and behavioral health providers and/or social

³ SAMHSA-HRSA Center for Integrated Solutions, "What is Integrated Care?"

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service organizations that participate in the NH Building Capacity for Transformation Section 1115 Waiver or are otherwise determined by DHHS to be an Integrated Delivery Network.

2.1.57.2 [Amendment #8:] Effective December 31, 2020, the phrase "Integrated Delivery Network" and acronym "IDN" is retained as informational due to the expiration of the NH Building Capacity for Transformation Section 1115 Waiver.

2.1.58 Limited English Proficiency (LEP)

2.1.58.1 "Limited English Proficiency (LEP)" means a Member's primary language is not English and the Member may have limited ability to read, write, speak or understand English.

2.1.59 Local Care Management

2.1.59.1 "Local Care Management" means the MCO engages in real-time, high-touch, or a supportive in-person Member engagement strategy used for building relationships with Members that includes consistent follow-up with Providers and Members to assure that selected Members are making progress with their care plans.

2.1.60 Long Term Services and Supports (LTSS)

2.1.60.1 "Long Term Services and Supports (LTSS)" means nursing facility services, all four of NH's Home and Community Based Care waivers, and services provided to children and families through the Division for Children, Youth and Families (DCYF).

2.1.61 Managed Care Information System (MCIS)

2.1.61.1 "Managed Care Information System (MCIS)" means a comprehensive, automated and integrated system that: collects, analyzes, integrates, and reports data [42 CFR 438.242(a)]; provides information on areas, including but not limited to utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility [42 CFR 438.242(a)]; collects and maintains data on Members and Providers, as specified in this Agreement and on all services furnished to Members, through an encounter data system [42 CFR 438.242(b)(2)]; is capable of meeting the requirements listed throughout this Agreement; and is capable of providing all of the data and information necessary for DHHS to meet State and federal Medicaid reporting and information regulations.

2.1.62 Managed Care Organization (MCO)

2.1.62.1 "Managed Care Organization (MCO)" means an entity that has a certificate of authority from the NH Insurance Department

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(NHID) and who contracts with DHHS under a comprehensive risk Agreement to provide health care services to eligible Members under the MCM program.

2.1.63 Marketing

2.1.63.1 "Marketing" means any communication from the MCO to a potential Member, or Member who is not enrolled in that MCO, that can reasonably be interpreted as intended to influence the Member to enroll with the MCO or to either not enroll, or disenroll from another DHHS contracted MCO. [42 CFR 438.104(a)]

2.1.64 Marketing Materials

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as Marketing to potential Members. [42 CFR 438.104(a)(ii)]

2.1.65 MCO Alternative Payment Model (APM) Implementation Plan

2.1.65.1 "MCO Alternative Payment Model (APM) Implementation Plan" means the MCO's plan for meeting the APM requirements described in this Agreement. The MCO APM Implementation Plan shall be reviewed and approved by DHHS:

2.1.66 MCO Data Certification

2.1.66.1 "MCO Data Certification" means data submitted to DHHS and certified by one of the following:

2.1.66.1.1 The MCO's Chief Executive Officer (CEO);

2.1.66.1.2 The MCO's Chief Financial Officer (CFO); or

2.1.66.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO.

2.1.67 MCO Formulary

2.1.67.1 "MCO Formulary" means the list of prescription drugs covered by the MCO and the tier on which each medication is placed, in compliance with the DHHS-developed Preferred Drug List (PDL) and 42 CFR 438.10(i).

2.1.68 MCO Quality Assessment and Performance Improvement (QAPI) Program

2.1.68.1 "MCO Quality Assessment and Performance Improvement (QAPI) Program" means an ongoing and comprehensive program for the services the MCO furnishes to Members consistent with the requirements of this Agreement and

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federal requirements for the QAPI program. [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)]

2.1.69 MCO Utilization Management Program

2.1.69.1 "MCO Utilization Management Program" means a program developed, operated, and maintained by the MCO that meets the criteria contained in this Agreement related to Utilization Management. The MCO Utilization Management Program shall include defined structures, policies, and procedures for Utilization Management.

2.1.70 Medicaid Director

2.1.70.1 "Medicaid Director" means the State Medicaid Director of NH DHHS.

2.1.71 Medicaid Management Information System (MMIS)

2.1.71.1 "Medicaid Management Information System (MMIS)" as defined by the CMS.gov glossary is: a CMS approved system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, Surveillance and Utilization Review Subsystem (SURS), Management and Administrative Reporting System (MARS), and potentially encounter processing.

2.1.72 Medicaid State Plan

2.1.72.1 "Medicaid State Plan" means an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state.

2.1.73 Medical Loss Ratio (MLR)

2.1.73.1 "Medical Loss Ratio (MLR)" means the proportion of premium revenues spent on clinical services and quality improvement, calculated in compliance with the terms of this Agreement and with all federal standards, including 42 CFR 438.8.

2.1.74 Medically Necessary

2.1.74.1 Per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Members under twenty-one (21) years of age;

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"Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

2.1.74.2 For Members twenty-one (21) years of age and older, "Medically Necessary" means services that a licensed Provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

2.1.74.2.1 Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the Member's illness, injury, disease, or its symptoms;

2.1.74.2.2 Not primarily for the convenience of the Member or the Member's family, caregiver, or health care Provider;

2.1.74.2.3 No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the Member's illness, injury, disease, or its symptoms; and

2.1.74.2.4 Not experimental, investigative, cosmetic, or duplicative in nature [He-W 530.01(e)].

2.1.75 Medication Assisted Treatment (MAT)

2.1.75.1 "Medication Assisted Treatment (MAT)" means the use of medications in combination with counseling and behavioral therapies for the treatment of Substance Use Disorder.⁴

2.1.76 Member

2.1.76.1 "Member" means an individual who is enrolled in managed care through an MCO having an Agreement with DHHS. [42 CFR 438.10(a)]

2.1.77 Member Advisory Board

2.1.77.1 "Member Advisory Board" means a group of Members that represents the Member population, established and facilitated by the MCO. The Member Advisory Board shall adhere to the requirements set forth in this Agreement.

⁴ SAHMSA-HRSA Center for Integrated Health Solutions, "Medication Assisted Treatment"

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2.1.78 Member Encounter Data (Encounter Data)

2.1.78.1 "Member Encounter Data ("Encounter Data")" means the information relating to the receipt of any item(s) or service(s) by a Member, under this Agreement, between DHHS and an MCO that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818.

2.1.79 Member Handbook

2.1.79.1 "Member Handbook" means a handbook based upon the model Member Handbook developed by DHHS and published by the MCO that enables the Member to understand how to effectively use the MCM program in accordance with this Agreement and 42 CFR 438.10(g).

2.1.80 National Committee for Quality Assurance (NCQA)

2.1.80.1 "National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

2.1.81 NCQA Health Plan Accreditation

"NCQA Health Plan Accreditation" means MCO accreditation, including the Medicaid module obtained from the NCQA, based on an assessment of clinical performance and consumer experience.

2.1.82 Neonatal Abstinence Syndrome (NAS)

2.1.82.1 "Neonatal Abstinence Syndrome (NAS)" means a constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids.⁵

2.1.83 Non-Emergency Medical Transportation (NEMT)

2.1.83.1 "Non-Emergency Medical Transportation (NEMT)" means transportation services arranged by the MCO and provided free of charge to Members who are unable to pay for the cost of transportation to Provider offices and facilities for Medically Necessary care and services covered by the Medicaid State Plan, regardless of whether those Medically Necessary services are covered by the MCO.

2.1.84 Non-Participating Provider

2.1.84.1 "Non-Participating Provider" means a person, health care Provider, practitioner, facility or entity acting within their scope of

⁵ CMCS Informational Bulletin, "Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants," Centers for Medicare and Medicaid Services, June 11, 2018

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practice or licensure, that does not have a written Agreement with the MCO to participate in the MCO's Provider network, but provides health care services to Members under appropriate scenarios (e.g., a referral approved by the MCO).

2.1.85 Non-Symptomatic Office Visits

2.1.85.1 "Non-Symptomatic Office Visits" means preventive care office visits available from the Member's Primary Care Provider (PCP) or another Provider within forty-five (45) calendar days of a request for the visit. Non-Symptomatic Office Visits may include, but are not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

2.1.86 Non-Urgent, Symptomatic Office Visits

2.1.86.1 "Non-Urgent, Symptomatic Office Visits" means routine care office visits available from the Member's PCP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of medical signs or symptoms not requiring immediate attention, but that require monitoring.

2.1.87 Ongoing Special Condition

2.1.87.1 "Ongoing Special Condition" means, in the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm; in the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; in the case of pregnancy, pregnancy from the start of the second trimester; in the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

2.1.88 Overpayments

2.1.88.1 "Overpayments" means any amount received to which the Provider is not entitled. An overpayment includes payment that should not have been made and payments made in excess of the appropriate amount.

2.1.89 Participating Provider

2.1.89.1 "Participating Provider" means a person, health care Provider, practitioner, facility, or entity, acting within the scope of practice and licensure, and who is under a written contract with the

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MCO to provide services to Members under the terms of this Agreement.

2.1.90 Peer Recovery Program

2.1.90.1 "Peer Recovery Program" means a program that is accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or another accrediting body approved by DHHS, is under contract with DHHS's contracted facilitating organization, or is under contract with DHHS's Bureau of Drug and Alcohol Services to provide Peer Recovery Support Services (PRSS).

2.1.91 Performance Improvement Project (PIP)

2.1.91.1 "Performance Improvement Project (PIP)" means an initiative included in the QAPI program that focuses on clinical and non-clinical areas. A PIP shall be developed in consultation with the EQRO. [42 CFR 438.330(b)(1); 42 CFR 438.330(d)(1); 42 CFR 438.330(a)(2)].

2.1.92 Physician Group

2.1.92.1 "Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its Members. An individual practice association is a Physician Group only if it is composed of individual physicians and has no Subcontracts with Physician Groups.

2.1.93 Physician Incentive Plan

2.1.93.1 "Physician Incentive Plan" means any compensation arrangement between the MCO and Providers that apply to federal regulations found at 42 CFR 422.208 and 42 CFR 422.210, as applicable to Medicaid managed care on the basis of 42 CFR 438.3(i).

2.1.94 Post-Stabilization Services

2.1.94.1 "Post-Stabilization Services" means contracted services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition. [42 CFR 438.114; 422.113]

2.1.95 Practice Guidelines

2.1.95.1 "Practice Guidelines" means evidence-based clinical guidelines adopted by the MCO that are in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines shall be based on valid and reasonable

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clinical evidence or a consensus of Providers in the particular field, shall consider the needs of Members, be adopted in consultation with Participating Providers, and be reviewed and updated periodically as appropriate.

2.1.96 Prescription Drug Monitoring Program (PDMP)

2.1.96.1 "Prescription Drug Monitoring Program (PDMP)" means the program operated by the NH Office of Professional Licensure and Certification that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances in NH.

2.1.97 Primary Care Provider (PCP)

2.1.97.1 "Primary Care Provider (PCP)" means a Participating Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the Continuity of Member Care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists (OB/GYNs), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All federal requirements applicable to primary care physicians shall also be applicable to PCPs as the term is used in this Agreement.

2.1.98 Prior Authorization

2.1.98.1 "Prior Authorization" means the process by which DHHS, the MCO, or another MCO participating in the MCM program, whichever is applicable, authorizes, in advance, the delivery of Covered Services based on factors, including but not limited to medical necessity, cost-effectiveness, and compliance with this Agreement.

2.1.99 Priority Population

2.1.99.1 "Priority Population" means a population that is most likely to have Care Management needs and be able to benefit from Care Management. The following groups are considered Priority Populations under this Agreement: Adults and Children with Special Health Care Needs, including, but not limited to, Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis, or with chronic pain; Members receiving services under HCBS waivers; Members identified as those with rising risk; individuals with

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high unmet resource needs; mothers of babies born with NAS; infants with NAS; pregnant women with Substance Use Disorder; intravenous drug users, including Members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use; individuals who have been in the ED for an overdose event in the last twelve (12) months; recently incarcerated individuals; individuals who have a suicide attempt in the last twelve (12) months and other Priority Populations as determined by the MCO and/or DHHS.

2.1.100 Program Start Date

2.1.100.1 "Program Start Date" means the date when the MCO is responsible for coverage of services to its Members in the MCM program, contingent upon Agreement approval by the Governor and Executive Council and DHHS's determination of successful completion of the Readiness Review period.

2.1.101 Provider

2.1.101.1 "Provider" means an individual medical, behavioral or social service professional, hospital, skilled nursing facility (SNF), other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

2.1.102 Provider Directory

2.1.102.1 "Provider Directory" means information on the MCO's Participating Providers for each of the Provider types covered under this Agreement, available in electronic form and paper form upon request to the Member in accordance with 42 CFR 438.10 and the terms of this Agreement.

2.1.103 Psychiatric Boarding

2.1.103.1 "Psychiatric Boarding" means a Member's continued physical presence in an emergency room or another temporary location after either completion of an Involuntary Emergency Admission (IEA) application, revocation of a conditional discharge, or commitment to New Hampshire Hospital or other designated receiving facility by a Court.

2.1.104 Qualified Bilingual/Multilingual Staff

2.1.104.1 "Qualified Bilingual/Multilingual Staff" means an employee of the MCO who is designated by the MCO to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the MCO that he or she is proficient in speaking and understanding spoken English and at

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least one (1) other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and is able to effectively, accurately, and impartially communicate directly with Members with LEP in their primary languages.

2.1.105 Qualified Interpreter for a Member with a Disability

2.1.105.1 "Qualified Interpreter for a Member with a Disability" means an interpreter who, via a remote interpreting service or an on-site appearance, adheres to generally accepted interpreter ethics principles, including Member confidentiality; and is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

2.1.105.2 Qualified interpreters can include, for example, sign language interpreters, oral transliterators (employees who represent or spell in the characters of another alphabet), and cued language transliterators (employees who represent or spell by using a small number of handshapes).

2.1.106 Qualified Interpreter for a Member with LEP

2.1.106.1 "Qualified Interpreter for a Member with LEP" means an interpreter who, via a remote interpreting service or an on-site appearance adheres to generally accepted interpreter ethics principles, including Member confidentiality; has demonstrated proficiency in speaking and understanding spoken English and at least one (1) other spoken language; and is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

2.1.107 Qualified Translator

2.1.107.1 "Qualified Translator" means a translator who adheres to generally accepted translator ethics principles, including Member confidentiality; has demonstrated proficiency in writing and understanding written English and at least one (1) other written language; and is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. [45 CFR 92.4, 92.201(d)-(e)]

2.1.108 Qualifying APM

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2.1.108.1 "Qualifying APM" means an APM approved by DHHS as consistent with the standards specified in this Agreement and in any subsequent DHHS guidance, including the DHHS Medicaid APM Strategy.

2.1.109 Recovery

2.1.109.1 "Recovery" means a process of change through which Members improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and Recovery support services for all populations.⁶

2.1.110 Referral Provider

2.1.110.1 "Referral Provider" means a Provider, who is not the Member's PCP, to whom a Member is referred for Covered Services.

2.1.111 Risk Scoring and Stratification

2.1.111.1 "Risk Scoring and Stratification" means the methodology to identify Members who are part of a Priority Population for Care Management and who should receive a Comprehensive Assessment. The MCO shall provide protocols to DHHS for review and approval on how Members are stratified by severity and risk level including details regarding the algorithm and data sources used to identify eligible Member for Care Management.

2.1.112 Rural Health Clinic (RHC)

2.1.112.1 "Rural Health Clinic (RHC)" means a clinic located in an area designated by DHHS as rural, located in a federally designated medically underserved area, or has an insufficient number of physicians, which meets the requirements under 42 CFR 491.

2.1.113 Second Opinion

2.1.113.1 "Second Opinion" means the opinion of a qualified health care professional within the Provider network, or the opinion of a Non-Participating Provider with whom the MCO has permitted the Member to consult, at no cost to the Member. [42 CFR 438.206(b)(3)]

2.1.114 Social Determinants of Health

2.1.114 "Social Determinants of Health" means a wide range of factors known to have an impact on healthcare, ranging from socioeconomic status, education and employment, to one's physical environment and access to healthcare.

⁶ SAMHSA, "Recovery and Recovery Support"

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2.1.115 State

2.1.115.1 The "State" means the State of New Hampshire and any of its agencies.

2.1.116 Subcontract

2.1.116.1 "Subcontract" means any separate contract or contract between the MCO and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the MCO is obligated to perform pursuant to this Agreement.

2.1.117 Subcontractor

2.1.117.1 "Subcontractor" means a person or entity that is delegated by the MCO to perform an administrative function or service on behalf of the MCO that directly or indirectly relates to the performance of all or a portion of the duties or obligations under this Agreement. A Subcontractor does not include a Participating Provider.

2.1.118 Substance Use Disorder

2.1.118.1 "Substance Use Disorder" means a cluster of symptoms meeting the criteria for Substance Use Disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th edition (2013), as described in He-W 513.02.

2.1.119 Substance Use Disorder Provider

2.1.119.1 "Substance Use Disorder Provider" means all Substance Use Disorder treatment and Recovery support service Providers as described in He-W 513.04.

2.1.120 Term

2.1.120.1 "Term" means the duration of this Agreement.

2.1.121 Third Party Liability (TPL)

2.1.121.1 "Third Party Liability (TPL)" means the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid State Plan.

2.1.121.2 By law, all other available third party resources shall meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

2.1.121.3 States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid State Plan.

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2.1.122 Transitional Care Management

2.1.122.1 "Transitional Care Management" means the responsibility of the MCO to manage transitions of care for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

2.1.122.2 The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

2.1.123 Transitional Health Care

2.1.123.1 "Transitional Health Care" means care that is available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

2.1.124 Transitional Home Care

2.1.124.1 "Transitional Home Care" means care that is available with a home care nurse, a licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or specialty care Provider or as part of the discharge plan.

2.1.125 Trauma Informed Care

2.1.125.1 "Trauma Informed Care" means a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for Recovery; recognizes the signs and symptoms of trauma in Members, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.⁷

2.1.126 Urgent, Symptomatic Office Visits

2.1.126.1 "Urgent, Symptomatic Office Visits" means office visits, available from the Member's PCP or another Provider within forty-eight (48) hours, for the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

⁷ SAMHSA, "Trauma Informed Approach and Trauma-Specific Interventions"

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2.1.127 Utilization Management

2.1.127.1 "Utilization Management" means the criteria of evaluating the necessity, appropriateness, and efficiency of Covered Services against established guidelines and procedures.

2.1.128 Value-Added Services

2.1.128.1 "Value-Added Services" means services not included in the Medicaid State Plan that the MCO elects to purchase and provide to Members at the MCO's discretion and expense to improve health and reduce costs. Value-Added Services are not included in capitation rate calculations.

2.1.129 Willing Provider

2.1.129.1 [Amendment #8:] "Willing Provider" means a Provider credentialed as a qualified treatment provider according to the requirements of DHHS and the MCO, who agrees to render services as authorized by the MCO and to comply with the terms of the MCO's Provider Agreement, including rates and policy manual.

2.2 Acronym List

- 2.2.1 AAP means American Academy of Pediatrics.
- 2.2.2 ABD means Acquired Brain Disorder.
- 2.2.3 ACT means Assertive Community Treatment.
- 2.2.4 ADA means Americans with Disabilities Act.
- 2.2.5 ADL means Activities of Daily Living.
- 2.2.6 ADT means Admission, Discharge and Transfer.
- 2.2.7 AIDS means Acquired Immune Deficiency Syndrome.
- 2.2.8 ANSA means Adult Needs and Strengths Assessment.
- 2.2.9 APM means Alternative Payment Model.
- 2.2.10 ARNP means Advanced Registered Nurse Practitioner.
- 2.2.11 ASAM means American Society of Addiction Medicine.
- 2.2.12 ASC means Accredited Standards Committee.
- 2.2.13 ASFRA means Assisted Suicide Funding Restriction Act.
- 2.2.14 ASL means American Sign Language.
- 2.2.15 BCPP means Breast and Cervical Cancer Program.

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- 2.2.16** [Amendment #7] ~~BHCTC means Behavioral Health Crisis Treatment Center.~~ Intentionally Left Blank.
- 2.2.17** CAHPS means Consumer Assessment of Healthcare Providers and Systems.
- 2.2.18** CANS means Child and Adolescent Needs and Strengths Assessment.
- 2.2.19** CAP means Corrective Action Plan.
- 2.2.20** CAPRSS means Council on Accreditation of Peer Recovery Support Services.
- 2.2.21** CARC means Claim Adjustment Reason Code.
- 2.2.22** CDT means Code on Dental Procedures and Nomenclature.
- 2.2.23** CEO means Chief Executive Officer.
- 2.2.24** CFI means Choices for Independence.
- 2.2.25** CFO means Chief Financial Officer.
- 2.2.26** CHIP means Children's Health Insurance Program.
- 2.2.27** CHIS means Comprehensive Health Care Information System.
- 2.2.28** CMH means Community Mental Health.
- 2.2.29** CMO means Chief Medical Officer.
- 2.2.30** CMR means Comprehensive Medication Review.
- 2.2.31** CMS means Centers for Medicare & Medicaid Services.
- 2.2.32** COB means Coordination of Benefits.
- 2.2.33** COBA means Coordination of Benefits Agreement.
- 2.2.34** CPT means Current Procedural Terminology.
- 2.2.35** CQI means Continuous Quality Improvement.
- 2.2.36** DBT means Dialectical Behavioral Therapy.
- 2.2.37** DCYF means New Hampshire Division for Children, Youth and Families.
- 2.2.38** DD means Developmental Disability.
- 2.2.39** DHHS means New Hampshire Department of Health and Human Services.
- 2.2.40** DME means Durable Medical Equipment.
- 2.2.41** DOB means Date of Birth.

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- 2.2.42 DOD means Date of Death.
 - 2.2.43 DOJ means (New Hampshire or United States) Department of Justice.
 - 2.2.44 DRA means Deficit Reduction Act.
 - 2.2.45 DSM means Diagnostic and Statistical Manual of Mental Disorders.
 - 2.2.46 DSRIP means The New Hampshire Delivery System Reform Incentive Payment Program.
 - 2.2.47 DUR means Drug Utilization Review.
 - 2.2.48 EBSE means Evidence-Based Supported Employment.
 - 2.2.49 ECI means Elderly and Chronically Ill.
 - 2.2.50 ED means Emergency Department.
 - 2.2.51 EDI means Electronic Data Interchange.
 - 2.2.52 EFT means Electronic Funds Transfer.
 - 2.2.53 EOB means Explanation of Benefits.
 - 2.2.54 EPSDT means Early and Periodic Screening, Diagnostic and Treatment.
 - 2.2.55 EQR means External Quality Review.
 - 2.2.56 EQRO means External Quality Review Organization.
 - 2.2.57 ERISA means Employees Retirement Income Security Act of 1974.
 - 2.2.58 EST means Eastern Standard Time.
 - 2.2.59 ETL means Extract, Transformation and Load.
 - 2.2.60 FAR means Federal Acquisition Regulation.
 - 2.2.61 FCA means False Claims Act.
 - 2.2.62 FDA means Food and Drug Administration for the United States Department of Health and Human Services.
 - 2.2.63 FFATA means Federal Funding Accountability & Transparency Act.
 - 2.2.64 FFS means Fee-for-Service.
 - 2.2.65 FPL means Federal Poverty Level.
 - 2.2.66 FQHC means Federally Qualified Health Center.
 - 2.2.67 HCBS means Home and Community Based Services.
 - 2.2.68 HCBS-I means Home and Community Based Services In Home Supports.

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- 2.2.69** HCPCS means Health Care Common Procedure Coding System.
- 2.2.70** HHS means United States Department of Health and Human Services.
- 2.2.71** HIPAA means Health Insurance Portability and Accountability Act.
- 2.2.72** HIPP means Health Insurance Premium Payment.
- 2.2.73** HITECH means Health Information Technology for Economic and Clinical Health Act of 2009.
- 2.2.74** HIV means Human Immunodeficiency Virus.
- 2.2.75** HMO means health maintenance organization.
- 2.2.76** HRSA means Health Resources and Services Administration for the United States Department of Health and Human Services.
- 2.2.77** I/T/U means Indian Tribe, Tribal Organization, or Urban Indian Organization.
- 2.2.78** IADL means Instrumental Activities of Daily Living.
- 2.2.79** IBNR means Incurred But Not Reported.
- 2.2.80** ICF means Intermediate Care Facility.
- 2.2.81** ID means Intellectual Disabilities.
- 2.2.82** IDN means Integrated Delivery Network.
- 2.2.83** IEA means Involuntary Emergency Admission.
- 2.2.84** IHCP means Indian Health Care Provider.
- 2.2.85** IHS means Indian Health Service.
- 2.2.86** IMD means Institution for Mental Disease.
- 2.2.87** IVR means Interactive Voice Response.
- 2.2.88** LEP means Limited English Proficiency.
- 2.2.89** LTSS means Long-Term Services and Supports.
- 2.2.90** MACRA means Medicare Access and CHIP Reauthorization Act of 2015.
- 2.2.91** MAT means Medication Assisted Treatment.
- 2.2.92** MCIS means Managed Care Information System.
- 2.2.93** MCM means Medicaid Care Management.
- 2.2.94** MCO means Managed Care Organization.
- 2.2.95** MED means Morphine Equivalent Dosing.

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- 2.2.96 MFCU means New Hampshire Medicaid Fraud Control Unit.
 - 2.2.97 MLADCs means Masters Licensed Alcohol and Drug Counselors.
 - 2.2.98 MLR means Medical Loss Ratio.
 - 2.2.99 MMIS means Medicaid Management Information System.
 - 2.2.100 NAS means Neonatal Abstinence Syndrome.
 - 2.2.101 NCPDP means National Council for Prescription Drug Programs.
 - 2.2.102 NCQA means National Committee for Quality Assurance.
 - 2.2.103 NEMT means Non-Emergency Medical Transportation.
 - 2.2.104 NH means New Hampshire.
 - 2.2.105 NHID means New Hampshire Insurance Department.
 - 2.2.106 NPI means National Provider Identifier.
 - 2.2.107 NPES means National Plan and Provider Enumeration System.
 - 2.2.108 OB/GYN means Obstetrics/Gynecology or Obstetricians/Gynecologists.
 - 2.2.109 OIG means Office of the Inspector General for the United States Department of Health and Human Services.
 - 2.2.110 OTP means Opioid Treatment Program.
 - 2.2.111 PBM means Pharmacy Benefits Manager.
 - 2.2.112 PCA means Personal Care Attendant.
 - 2.2.113 PCP means Primary Care Provider.
 - 2.2.114 PDL means Preferred Drug List.
 - 2.2.115 PDMP means Prescription Drug Monitoring Program.
 - 2.2.116 PHI means Protected Health Information.
 - 2.2.117 PI means Personal Information.
 - 2.2.118 PIP means Performance Improvement Project.
 - 2.2.119 POS means Point of Service.
 - 2.2.120 PRSS means Peer Recovery Support Services.
 - 2.2.121 QAPI means Quality Assessment and Performance Improvement.
 - 2.2.122 QOS means Quality of Service.
 - 2.2.123 RARC means Reason and Remark Codes.

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- 2.2.124 RFP means Request for Proposal.
- 2.2.125 RHC means Rural Health Clinic.
- 2.2.126 SAMHSA means Substance Abuse and Mental Health Services Administration for the United States Department of Health and Human Services.
- 2.2.127 SBIRT means Screening, Brief Intervention, and Referral to Treatment.
- 2.2.128 SED means Serious Emotional Disturbance.
- 2.2.129 SHIP means State's Health Insurance Assistance Program.
- 2.2.130 SIU means Special Investigations Unit.
- 2.2.131 SMART means Specific, Measurable, Attainable, Realistic, and Time Relevant.
- 2.2.132 SMDL means State Medicaid Director Letter.
- 2.2.133 SMI means Severe Mental Illness.
- 2.2.134 SNF means Skilled Nursing Facility.
- 2.2.135 SPMI means Severe or Persistent Mental Illness.
- 2.2.136 SSADMF means Social Security Administration Death Master File.
- 2.2.137 SSAE means Statement on Standards for Attestation Engagements.
- 2.2.138 SSI means Supplemental Security Income.
- 2.2.139 SSN means Social Security Number.
- 2.2.140 TAP means Technical Assistance Publication.
- 2.2.141 TDD means Telecommunication Device for Deaf Persons.
- 2.2.142 TPL means Third Party Liability.
- 2.2.143 TTY means Teletypewriter.
- 2.2.144 UAT means User Acceptance Testing.
- 2.2.145 UDS means Urine Drug Screenings.
- 2.2.146 VA means United States Department of Veterans Affairs.

3 GENERAL TERMS AND CONDITIONS

3.1 Program Management and Planning

3.1.1 General

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3.1.1.1 The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to Members enrolled in the MCM program and who are enrolled in the MCO.

3.1.1.2 The MCO shall provide for all aspects of administrating and managing such program and shall meet all service and delivery timelines and milestones specified by this Agreement, applicable law or regulation incorporated directly or indirectly herein, or the MCM program.

3.1.2 Representation and Warranties

3.1.2.1 The MCO represents and warrants that it shall fulfill all obligations under this Agreement and meet the specifications as described in the Agreement during the Term, including any subsequently negotiated, and mutually agreed upon, specifications.

3.1.2.2 The MCO acknowledges that, in being awarded this Agreement, DHHS has relied upon all representations and warrants made by the MCO in its response to the DHHS Request for Proposal (RFP) attached hereto as Exhibit M, including any addenda, with respect to delivery of Medicaid managed care services and affirms all representations made therein.

3.1.2.3 The MCO represents and warrants that it shall comply with all of the material submitted to, and approved by DHHS as part of its Readiness Review. Any material changes to such approved materials or newly developed materials require prior written approval by DHHS before implementation.

3.1.2.4 The MCO shall not take advantage of any errors and/or omissions in the RFP or the resulting Agreement and amendments.

3.1.2.4.1 The MCO shall promptly notify DHHS of any such errors and/or omissions that are discovered.

3.1.2.5 This Agreement shall be signed and dated by all parties, and is contingent upon approval by Governor and Executive Council.

3.1.3 Program Management Plan

3.1.3.1 The MCO shall develop and submit a Program Management Plan for DHHS's review and approval.

3.1.3.2 The MCO shall provide the initial Program Management Plan to DHHS for review and approval at the beginning of the Readiness Review period; in future years, any modifications to the Program Management Plan shall be presented for prior approval to

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DHHS at least sixty (60) calendar days prior to the coverage year. The Program Management Plan shall:

3.1.3.2.1 Elaborate on the general concepts outlined in the MCO's Proposal and the section headings of the Agreement;

3.1.3.2.2 Describe how the MCO shall operate in NH by outlining management processes such as workflow, overall systems as detailed in the section headings of Agreement, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to Member and Provider experiences;

3.1.3.2.3 Describe how the MCO shall ensure timely notification to DHHS regarding:

3.1.3.2.3.1. Expected or unexpected interruptions or changes that impact MCO policy, practice, operations, Members or Providers,

3.1.3.2.3.2. Correspondence received from DHHS on emergent issues and non-emergent issues; and

3.1.3.2.4 Outline the MCO integrated organizational structure including NH-based resources and its support from its parent company, affiliates, or Subcontractors.

3.1.3.3 On an annual basis, the MCO shall submit to DHHS either a certification of "no change" to the Program Management Plan or a revised Program Management Plan together with a redline that reflects the changes made to the Program Management Plan since the last submission.

3.1.4 Key Personnel Contact List

3.1.4.1 The MCO shall submit a Key Personnel Contact List to DHHS that includes the positions and associated information indicated in Section 3.15.1 (Key Personnel) of this Agreement at least sixty (60) calendar days prior to the scheduled start date of the MCM program.

3.1.4.2 Thereafter, the MCO shall submit an updated Contact List immediately upon any Key Personnel staff changes.

3.2 Agreement Elements

3.2.1 The Agreement between the parties shall consist of the following:

3.2.1.1 General Provisions, Form Number P-37

3.2.1.2 Exhibit A: Scope of Services.

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- 3.2.1.3 Exhibit B: Method and Conditions Precedent to Payment
- 3.2.1.4 Exhibit C: Special Provisions
- 3.2.1.5 Exhibit C-1: Revisions to General Provisions
- 3.2.1.6 Exhibit D: Certification Regarding Drug Free Workplace Requirements
- 3.2.1.7 Exhibit E: Certification Regarding Lobbying
- 3.2.1.8 Exhibit F: Certification Regarding Debarment, Suspension, and Other Responsibility Matters
- 3.2.1.9 Exhibit G: Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections
- 3.2.1.10 Exhibit H: Certification Regarding Environmental Tobacco Smoke
- 3.2.1.11 Exhibit I: Health Insurance Portability Act Business Associate
- 3.2.1.12 Exhibit J: Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.
- 3.2.1.13 Exhibit K: DHHS Information Security Requirements.
- 3.2.1.14 Exhibit L: MCO Implementation Plan
- 3.2.1.15 Exhibit M: MCO Proposal submitted in response to RFP-2019-OMS-02-MANAG, by reference.
- 3.2.1.16 Exhibit N: Liquidated Damages Matrix
- 3.2.1.17 Exhibit O: Quality and Oversight Reporting Requirements
- 3.2.1.18 Exhibit P: MCO Program Oversight Plan

3.3 Conflicts Between Documents

3.3.1 In the event of any conflict or contradiction between or among the documents which comprise the Agreement, as listed in Section 3.2 (Agreement Elements) above, the documents shall control in the order of precedence as follows:

- 3.3.1.1 First: P-37, Exhibit A Scope of Services, Exhibit B Method and Conditions Precedent to Payment, Exhibit C Special Provisions and Exhibit C-1 Revisions to General Provisions, Exhibit N Liquidated Damages Matrix, Exhibit O Quality and Oversight Reporting Requirements

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3.3.1.2 Second: Exhibit I Health Insurance Portability Act Business Associate and Exhibit K DHHS Information Security Requirements

3.3.1.3 Third: Exhibits D through H, Exhibit J, and Exhibit L, Exhibit P, Exhibit M.

3.4 Delegation of Authority

3.4.1 Whenever, by any provision of this Agreement, any right, power, or duty is imposed or conferred on DHHS, the right, power, or duty so imposed or conferred is possessed and exercised by the Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of the DHHS and NHID.

3.5 Authority of the New Hampshire Insurance Department

3.5.1 Pursuant to this Agreement and under the laws and rules of the State, the NHID shall have authority to regulate and oversee the licensing requirements of the MCO to operate as a health maintenance organization (HMO) in the State of New Hampshire.

3.5.2 The MCO is subject to all applicable laws and rules (and as subsequently amended) including but not limited to RSA 420-B; Managed Care Law and Rules RSA. 420-J; and Admin Rules 2700; compliance with Bulletin INSNO. 12-015-AB, and further updates made by the NHID; and the NH Comprehensive Health Care Information System (CHIS) data reporting submission under NHID rules/bulletins.

3.6 Time of the Essence

3.6.1 In consideration of the need to ensure uninterrupted and continuous services under the MCM program, time is of the essence in the performance of the MCO's obligations under the Agreement.

3.7 CMS Approval of Agreement and Any Amendments

3.7.1 This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to and contingent upon the approval of CMS.

3.7.2 This Agreement submission shall be considered complete for CMS's approval if:

3.7.2.1 All pages, appendices, attachments, etc. were submitted to CMS; and

3.7.2.2 Any documents incorporated by reference (including but not limited to State statute, regulation, or other binding document,

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such as a Member Handbook) to comply with federal regulations and the requirements of this review tool were submitted to CMS.

3.7.3 As part of this Agreement, DHHS shall submit to CMS for review and approval the MCO rate certifications concurrent with the review and approval process for this Agreement. [42 CFR 438.7(a)]

3.7.4 DHHS shall also submit to CMS for review and approval any Alternative Payment arrangements or other Provider payment arrangement initiatives based on DHHS's description of the initiatives submitted and approved outside of the Agreement. [42 CFR 438.6(c)]

3.8 Cooperation With Other Vendors and Prospective Vendors

3.8.1 This is not an exclusive Agreement and DHHS may award simultaneous and/or supplemental contracts for work related to the Agreement, or any portion thereof. The MCO shall reasonably cooperate with such other vendors, and shall not knowingly or negligently commit or permit any act that may interfere with the performance of work by any other vendor, or act in any way that may place Members at risk.

3.8.2 The MCO is required to notify DHHS within twelve (12) hours of a report by a Member, Member's relative, guardian or authorized representative of an allegation of a serious criminal offense against the Member by any employee of the MCO, its subcontractor or a Provider.

3.8.2.1 For the purpose of this Agreement, a serious criminal offense should be defined to include murder, arson, rape, sexual assault, assault, burglary, kidnapping, criminal trespass, or attempt thereof.

3.8.3 The MCO's notification shall be to a member of senior management of DHHS such as the Commissioner, Deputy Commissioner, Associate Commissioner, Medicaid Director, or Deputy Medicaid Director.

3.9 Renegotiation and Re-Procurement Rights

3.9.1 Renegotiation of Agreement

3.9.1.1 Notwithstanding anything in the Agreement to the contrary, DHHS may at any time during the Term exercise the option to notify the MCO that DHHS has elected to renegotiate certain terms of the Agreement.

3.9.1.2 Upon the MCO's receipt of any notice pursuant to this Section 3.9. (Renegotiation and Re-Procurement Rights) of the Agreement, the MCO and DHHS shall undertake good faith negotiations of the subject terms of the Agreement, and may execute

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an amendment to the Agreement subject to approval by Governor and Executive Council.

3.9.2 Re-Procurement of the Services or Procurement of Additional Services

3.9.2.1 Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected MCO's services and/or deliverables provided during any period of the Agreement, DHHS may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the scope of work covered by the Agreement or scope of work similar or comparable to the scope of work performed by the MCO under the Agreement.

3.9.2.2 DHHS shall give the MCO ninety (90) calendar days' notice of intent to replace another MCO participating in the MCM program or to add an additional MCO or other contractors to the MCM program.

3.9.2.3 If, upon procuring the services or deliverables or any portion of the services or deliverables from a Subcontractor in accordance with this section, DHHS, in its sole discretion, elects to terminate this Agreement, the MCO shall have the rights and responsibilities set forth in Section 7 (Termination of Agreement) and Section 5.7 (Dispute Resolution Process).

3.10 Organization Requirements

3.10.1 General Organization Requirements

3.10.1.1 As a condition to entering into this Agreement, the MCO shall be licensed by the NHID to operate as an HMO in the State as required by RSA 420-B, and shall have all necessary registrations and licensures as required by the NHID and any relevant State and federal laws and regulations.

3.10.1.2 As a condition to entering into this Agreement, and during the entire Agreement Term, the MCO shall ensure that its articles of incorporation and bylaws do not prohibit it from operating as an HMO or performing any obligation required under this Agreement.

3.10.1.3 The MCO shall not be located outside of the United States. [42 CFR 438.602(i)] The MCO is prohibited from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories.

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3.10.1.4 ~~[Amendment #9]~~[Amendment #8:] At the Department's discretion, the MCO shall initiate Centers for Medicare and Medicaid defined notification processes and application as may be appropriate to effectuate an integrated Medicare Advantage Duals-Special Needs Plan (D-SNP) targeting a beneficiary effective date at a date to be determined of January 1, 2024.

3.10.2 Articles

3.10.2.1 The MCO shall provide, by the beginning of each Agreement year and at the time of any substantive changes, written assurance from MCO's legal counsel that the MCO is not prohibited by its articles of incorporation from performing the services required under this Agreement.

3.10.3 Ownership and Control Disclosures

3.10.3.1 The MCO shall submit to DHHS the name of any persons or entities with an ownership or control interest in the MCO that:

3.10.3.1.1 Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the MCO's equity;

3.10.3.1.2 Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the MCO if that interest equals at least five percent (5%) of the value of the MCO's assets; or

3.10.3.1.3 Is an officer or director of an MCO organized as a corporation or is a partner in an MCO organized as a partnership. [Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]

3.10.3.2 The submission shall include for each person or entity, as applicable:

3.10.3.2.1 The address, including the primary business address, every business location, and P.O. Box address, for every entity;

3.10.3.2.2 The date of birth (DOB) and social security number (SSN) of any individual;

3.10.3.2.3 Tax identification number(s) of any corporation;

3.10.3.2.4 Information on whether an individual or entity with an ownership or control interest in the MCO is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

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3.10.3.2.5 Information on whether a person or corporation with an ownership or control interest in any Subcontractor in which the MCO has a five percent (5%) or more interest is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

3.10.3.2.6 The name of any other disclosing entity, as such term is defined in 42 CFR 455.101, in which an owner of the MCO has an ownership or control interest;

3.10.3.2.7 The name, address, DOB, and SSN of any managing employee of the MCO, as such term is defined by 42 CFR 455.101; and

3.10.3.2.8 Certification by the MCO's CEO that the information provided in this Section 3.10.3 (Ownership and Control Disclosures) to DHHS is accurate to the best of his or her information, knowledge, and belief.

3.10.3.3 The MCO shall disclose the information set forth in this Section 3.10.3 (Ownership and Control Disclosures) on individuals or entities with an ownership or control interest in the MCO to DHHS at the following times:

3.10.3.3.1 At the time of Agreement execution;

3.10.3.3.2 When the Provider or disclosing entity submits a Provider application;

3.10.3.3.3 When the Provider or disclosing entity executes a Provider agreement with DHHS;

3.10.3.3.4 Upon request of DHHS during the revalidation of the Provider enrollment; and

3.10.3.3.5 Within thirty-five (35) calendar days after any change in ownership of the disclosing entity. [Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 103; 42 CFR 455.104(c)(1) and (4)]

3.10.3.4 DHHS shall review the ownership and control disclosures submitted by the MCO and any Subcontractors. [42 CFR 438.602(c); 42 CFR 438.608(c)]

3.10.3.5 The MCO shall be fined in accordance with Exhibit N (Liquidated Damages Matrix) for any failure to comply with ownership disclosure requirements detailed in this Section.

3.10.4 Change in Ownership or Proposed Transaction

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3.10.4.1 The MCO shall inform DHHS and the NHID of its intent to merge with or be acquired, in whole or in part, by another entity or another MCO or of any change in control within seven (7) calendar days of a management employee learning of such intent. The MCO shall receive prior written approval from DHHS and the NHID prior to taking such action.

3.10.5 Prohibited Relationships

3.10.5.1 Pursuant to Section 1932(d)(1)(A) of the Social Security Act (42 USC 1396u-2(d)(1)(A)), the MCO shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the MCO's equity who has been, or is affiliated with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(c)(2); Exec. Order No. 12549]

3.10.5.2 The MCO shall not have an employment, consulting, or any other contractual agreement or engage a Subcontractor, vendor or Provider who is a Sanctioned Individual or entity. In accordance with Section 1128(b)(8) of the Social Security Act, a Sanctioned Individual means a person who:

3.10.5.2.1 Has a direct or indirect ownership or control interest of 5 percent (5%) or more in the entity, and:

3.10.5.2.1.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.1.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.1.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.2 Has an ownership or control interest (as defined in Section 1124(a)(3) of the Social Security Act) in the entity, and:

3.10.5.2.2.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled

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substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.2.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.2.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.3 Is an officer, director, agent, or managing employee of the MCO, and:

3.10.5.2.3.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud, or

3.10.5.2.3.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.3.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.4 No longer has direct or indirect ownership or control interest of 5 percent (5%) or more in the MCO or no longer has an ownership or control interest defined under Section 1124(a)(3) of the Social Security Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who:

3.10.5.2.4.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.4.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.4.3. Has been excluded from participation under a program under title XVIII or under a state health care program. [Section 1128(b)(8) of the Social Security Act]

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3.10.5.3 The MCO shall retain any data, information, and documentation regarding the above described relationships for a period of no less than ten (10) years.

3.10.5.4 Within five (5) calendar days of discovery, the MCO shall provide written disclosure to DHHS, and Subcontractors shall provide written disclosure to the MCO, which shall provide the same to DHHS, of any individual or entity (or affiliation of the individual or entity) who/that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or prohibited affiliation under 42 CFR 438.610. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.608(c)(1); 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(b); 42 CFR 438.610(c)(1) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549]

3.10.5.5 If DHHS learns that the MCO has a prohibited relationship with an individual or entity that (i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the MCO has relationship with an individual who is an affiliate of such an individual; (ii) is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act, DHHS may:

3.10.5.5.1 Terminate the existing Agreement with the MCO;

3.10.5.5.2 Continue an existing Agreement with the MCO unless the HHS Secretary directs otherwise;

3.10.5.5.3 Not renew or extend the existing Agreement with the MCO unless the HHS Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliation. [42 CFR 438.610(d)(2)-(3); 42 CFR 438.610(a); 42 CFR 438.610(b); Exec. Order No. 12549]

3.10.6 Background Checks and Screenings

3.10.6.1 The MCO shall perform criminal history record checks on its owners, directors, and managing employees, as such terms are defined in 42 CFR Section 455.101 and clarified in applicable

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subregulatory guidance such as the Medicaid Provider Enrollment Compendium.

3.10.6.2 [Amendment #8:] The MCO or its Subcontractors shall conduct ~~monthly~~ background checks upon hire and monthly on all ~~directors, officers, employees~~ (or contractors and their employees) ~~contractors or Subcontractors~~ to ensure that the MCO and Subcontractors ~~it~~ does not employ or contract with any individual or entity:

3.10.6.2.1 Convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act;

3.10.6.2.2 Debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and/or

3.10.6.2.3 Is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act. [[42 CFR 438.808(a); 42 CFR 438.808(b)(1); 42 CFR 431.55(h); section 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; SMDL #09-001; 76 Fed. Reg. 5862, 5897 (February 2, 2011)]

3.10.6.3 [Amendment #8:] In addition, the MCO or its Subcontractor shall conduct screenings upon hire and monthly of its employees (except its directors and officers), and contractors and MCO Subcontractors' contractor employees (except its directors and officers) to ensure that none of them appear on: ~~In addition, the MCO shall conduct screenings of its directors, officers, employees, and contractors and Subcontractors to ensure that none of them appear on:~~

3.10.6.3.1 HHS-OIG's List of Excluded Individuals/Entities;

3.10.6.3.2 [Amendment #8:] The System of Award Management; and

3.10.6.3.3 [Amendment #8:] Intentionally left blank ~~The Social Security Administration Death Master File;~~

3.10.6.3.4 [Amendment #8:] The list maintained by the Office of Foreign Assets Control; ~~and/or~~

3.10.6.3.5 To the extent applicable, NPPES (collectively, these lists are referred to as the "Exclusion Lists").

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~~3.10.6.4 [Amendment #8:] Intentionally left blank The MCO shall conduct screenings of all of its directors, officers, employees and Subcontractors monthly to ensure that none of the foregoing appear on any of the Exclusion Lists and that it continues to comply with Section 3.10.3 (Ownership and Control Disclosures) above. [SMDL #09-001; 76 Fed. Reg. 5862, 5897 (February 2, 2011)]~~

~~3.10.6.5 [Amendment #8:] The MCO shall certify to DHHS annually that it or its Subcontractors performs screenings upon hire and monthly thereafter against the Exclusion Lists and that neither the MCO nor its Subcontractors, including contractor employees of MCO Subcontractors, have any employees, directly or indirectly, with: The MCO shall certify to DHHS annually that it performs monthly screenings against the Exclusion Lists and that it does not have any director or officer or employ or contract, directly or indirectly, with:~~

~~3.10.6.5.1 Any individual or entity excluded from participation in the federal health care program;~~

~~3.10.6.5.2 Any entity for the provision of such health care, utilization review, medical social work, or administrative services through an excluded individual or entity or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;~~

~~3.10.6.5.3 Any individual or entity excluded from Medicare, Medicaid or NH participation by DHHS per the DHHS system of record;~~

~~3.10.6.5.4 Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act; and/or~~

~~3.10.6.5.5 Any individual entity appearing on any of the Exclusion Lists.~~

~~3.10.6.6 [Amendment #8:] In the event that the MCO or its Subcontractor identifies that it has employed or contracted with a person or entity which would make the MCO unable to certify as required under this Section 3.10.6 (Background Checks and Screenings) or Section 3.10.3 (Ownership and Control Disclosures) above, then the MCO should notify DHHS in writing and shall begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved waiver program.~~

~~3.10.6.7 [Amendment #8:] The MCO shall maintain documentation to ensure screenings have been completed by Subcontractors and reviewed by the MCO monthly.~~

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3.10.7 Conflict of Interest

3.10.7.1 The MCO shall ensure that safeguards, at a minimum equal to federal safeguards (41 USC 423, Section 27), are in place to guard against conflict of interest. [Section 1923(d)(3) of the Social Security Act; SMDL 12/30/97]. The MCO shall report transactions between the MCO and parties in interest to DHHS and any other agency as required, and make it available to MCO Members upon reasonable request. [Section 1903(m)(4)(B) of the Social Security Act]

3.10.7.2 The MCO shall report to DHHS and, upon request, to the HHS Secretary, the HHS Inspector General, and the Comptroller General a description of transactions between the MCO and a party in interest (as defined in Section 1318(b) of the Social Security Act), including the following transactions:

3.10.7.2.1 Any sale or exchange, or leasing of any property between the MCO and such a party;

3.10.7.2.2 Any furnishing for consideration of goods, services (including management services), or facilities between the MCO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and

3.10.7.2.3 Any lending of money or other extension of credit between the MCO and such a party. [Section 1903(m)(4)(A) of the Social Security Act; Section 1318(b) of the Social Security Act]

3.11 Confidentiality

3.11.1 Confidentiality of DHHS Information and Records

3.11.1.1 All information, reports, and records maintained hereunder or collected in connection with the performance of the services under the Agreement shall be confidential and shall not be disclosed by the MCO; provided however, that pursuant to State rules, State and federal laws and the regulations of DHHS regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Agreement; and provided further, that the use or disclosure by any party of any information concerning a Member for any purpose not directly connected with the administration of DHHS or the MCO's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his or her attorney or guardian.

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3.11.2 Request to DHHS of MCO Confidential or Proprietary Data or Information

3.11.2.1 DHHS may, in the course of carrying out its responsibilities under this Agreement, have or gain access to confidential or proprietary data or information owned or maintained by the MCO.

3.11.2.2 Insofar as the MCO seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the MCO shall clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential.

3.11.2.3 The MCO acknowledges that DHHS is subject to the Right-to-Know Law, RSA Chapter 91-A.

3.11.2.4 DHHS shall maintain the confidentiality of the identified Confidential Information insofar as it is consistent with applicable laws, rules, or regulations, including but not limited to RSA Chapter 91-A.

3.11.2.5 In the event DHHS receives a request for the information identified by the MCO as confidential, DHHS shall notify the MCO in writing and specify the date DHHS intends to release the requested information.

3.11.2.6 Any effort to prohibit or enjoin the release of the information shall be the MCO's responsibility and at the MCO's sole expense.

3.11.2.7 If the MCO fails to obtain a valid and enforceable court order in the State of New Hampshire enjoining the disclosure of the requested information within fifteen (15) business days of DHHS's written notification, DHHS may release the information on the date DHHS specified in its notice to the MCO without incurring any liability to the MCO.

3.12 Privacy and Security of Members' Information

3.12.1 The MCO shall be in compliance with privacy and security policies established by State or federal law, regulations or guidelines, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and their respective implementing regulations, federal statutes and regulations governing the privacy of Substance Use Disorder patient records (42 CFR, Part 2), and all applicable State statutes, rules and regulations including, but not limited to, RSA 167:30.

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3.12.2 The MCO shall protect the confidentiality of all DHHS records with identifying medical information in them. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(ii)]

3.12.3 The MCO shall execute as part of this Agreement, a Business Associate Agreement, as such term is defined by HIPAA, and the DHHS information security requirements as outlined in Exhibit I (HIPAA Business Associate Agreement), governing the permitted uses, disclosure and security of Protected Health Information (PHI), as such term is defined by HIPAA, and as provided by DHHS to the MCO.

3.12.4 The MCO shall ensure that if Member Substance Use Disorder records or data protected by 42 CFR Part 2 are created, maintained, or disclosed, any record or data shall be safeguarded according to the requirements found in 42 CFR Part 2, and that Member consent is obtained as required by 42 CFR Part 2.

3.12.5 The MCO shall ensure that it secures and protects the State and DHHS data when such data resides on the MCO's network, when in transit, and while stored and cached.

3.12.6 State and DHHS data shall be encrypted while in transit.

3.12.7 The MCO shall ensure that it secures and protects DHHS data if any DHHS data or Member records or data are transmitted by fax, and shall ensure that appropriate notices relating to confidentiality or erroneous transmission are used with each fax transmission.

3.12.8 With the exception of submission to the CHIS or other requirements of State or federal law or the terms of this Agreement, claims and Member data on NH Medicaid Members may not be released to any party without the express written consent of DHHS.

3.12.9 The MCO shall maintain written policies and procedures ensuring compliance with this Section 3.12 (Privacy and Security of Members' Information), which shall be available to DHHS upon request.

3.12.10 In the event that the MCO or one of its Subcontractors had a breach, as such term is defined by HIPAA, or had an unauthorized disclosure of State or DHHS data, the MCO shall notify DHHS within two (2) hours of knowledge that such breach or unauthorized disclosure has been confirmed. Failure to adequately protect Member information, DHHS claims, and other data may subject the MCO to sanctions and/or the imposition of liquidated damages in accordance with Section 5.5.2 (Liquidated Damages).

3.13 Compliance With State and Federal Laws

3.13.1 General Requirements

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3.13.1.1 [Amendment #10:] The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.13 (Compliance with State and Federal Laws), and any laws, regulations or administrative rules effective after the execution of this Agreement. The MCO shall comply with any applicable federal and State laws that pertain to Member rights and ensure that its employees and Participating Providers observe and protect those rights. [42 CFR 438.100(a)(2)]

3.13.1.2 The MCO shall comply, at a minimum, with the following:

3.13.1.2.1 Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. Section 1395 et seq.; Related rules: Title 42 Chapter IV;

3.13.1.2.2 Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. Section 1396 et seq. (specific to managed care: Section 1902(a)(4), 1903(m), 1905(t), and 1932 of the SSA); Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR Section 438; see also 431 and 435);

3.13.1.2.3 CHIP: Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397; Regulations promulgated thereunder: 42 CFR 457;

3.13.1.2.4 Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;

3.13.1.2.5 State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;

3.13.1.2.6 State administrative rules and laws pertaining to confidentiality;

3.13.1.2.7 American Recovery and Reinvestment Act;

3.13.1.2.8 Title VI of the Civil Rights Act of 1964;

3.13.1.2.9 The Age Discrimination Act of 1975;

3.13.1.2.10 The Rehabilitation Act of 1973;

3.13.1.2.11 Title IX of the Education Amendments of 1972 (regarding education programs and activities);

3.13.1.2.12 The ADA;

3.13.1.2.13 42 CFR Part 2; and

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3.13.1.2.14 Section 1557 of the Affordable Care Act. [42 CFR 438.3(f)(1); 42 CFR 438.100(d)]

3.13.1.3 [Amendment #10:] The MCO shall comply with all aspects of the DHHS Sentinel Event Reporting and Review Policy ~~PR 10-01, effective September 2010~~ PO.1003, and any subsequent versions and/or amendments;

3.13.1.3.1 [Amendment #10:] The MCO shall 1) cooperate with review of any reported any investigation of a Ssentinel event, including involvement in the Sentinel Event Review team, and provide any additional reporting information requested by DHHS, and 2) participate in a DHHS sentinel event review, if requested to conduct the Sentinel Event Review;

3.13.1.3.2 The MCO shall report to DHHS within twenty-four (24) hours any time a sentinel event occurs with one of its Members. This does not replace the MCO's responsibility to notify the appropriate authority if the MCO suspects a crime has occurred;

3.13.1.3.3 The MCO shall comply with all statutorily mandated reporting requirements, including but not limited to, RSA 161-F:42-54 and RSA 169-C:29;

3.13.1.3.4 In instances where the time frames detailed in the Agreement conflict with those in the DHHS Sentinel Event Policy, the policy requirements will prevail.

3.13.2 Non-Discrimination

3.13.2.1 The MCO shall require Participating Providers and Subcontractors to comply with the laws listed in Section 3.13.1 (General Requirements) above, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. [42 CFR 438.3(d)(4)]

3.13.3 Reporting Discrimination Grievances

3.13.3.1 The MCO shall forward to DHHS copies of all grievances alleging discrimination against Members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability or

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gender identity for review and appropriate action within three (3) business days of receipt by the MCO.

3.13.3.2 Failure to submit any such grievance within three (3) business days may result in the imposition of liquidated damages as outlined in Section 5.5.2. (Liquidated Damages).

3.13.4 Americans with Disabilities Act

3.13.4.1 The MCO shall have written policies and procedures that ensure compliance with requirements of the ADA, and a written plan to monitor compliance to determine the ADA requirements are being met.

3.13.4.2 The ADA compliance plan shall be sufficient to determine the specific actions that shall be taken to remove existing barriers and/or to accommodate the needs of Members who are qualified individuals with a disability.

3.13.4.3 The ADA compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all Members who are qualified individuals with a disability, including but not limited to street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

3.13.4.4 A "Qualified Individual with a Disability," defined pursuant to 42 U.S.C. Section 12131(2), is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of Auxiliary Aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

3.13.4.5 The MCO shall require Participating Providers and Subcontractors to comply with the requirements of the ADA. In providing Covered Services, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid Members who are qualified individuals with disabilities covered by the provisions of the ADA.

3.13.4.6 The MCO shall survey Participating Providers of their compliance with the ADA using a standard survey document that shall be provided by DHHS. Completed survey documents shall be kept on file by the MCO and shall be available for inspection by DHHS.

3.13.4.7 The MCO shall, in accordance with Exhibit G (Certification Regarding ADA Compliance), annually submit to DHHS a written

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certification that it is conversant with the requirements of the ADA, that it is in compliance with the ADA, that it has complied with this Section 3.13.4 (Americans with Disabilities Act) of the Agreement, and that it has assessed its Participating Provider network and certifies that Participating Providers meet ADA requirements to the best of the MCO's knowledge.

3.13.4.8 The MCO warrants that it shall hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the MCO to be in compliance with the ADA.

3.13.4.9 Where applicable, the MCO shall abide by the provisions of Section 504 of the Federal Rehabilitation Act of 1973, as amended, 29 U.S.C. Section 794, regarding access to programs and facilities by people with disabilities.

3.13.5 Non-Discrimination in Employment

3.13.5.1 The MCO shall not discriminate against any employee or applicant for employment because of age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

3.13.5.2 The MCO shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

3.13.5.3 Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship.

3.13.5.4 The MCO agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

3.13.5.5 The MCO shall, in all solicitations or advertisements for employees placed by or on behalf of the MCO, state that all qualified applicants shall receive consideration for employment without regard to age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

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3.13.5.6 The MCO shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other agreement or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of the MCO's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.13.5.7 The MCO shall comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.13.5.8 The MCO shall furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and shall permit access to its books, records, and accounts by DHHS and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.13.5.9 The MCO shall include the provisions described in this Section 3.13.5 (Non-Discrimination in Employment) in every contract with a Subcontractor or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions shall be binding upon each Subcontractor or vendor.

3.13.5.10 The MCO shall take such action with respect to any contract with a Subcontractor or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance, provided, however, that in the event the MCO becomes involved in, or is threatened with, litigation with a Subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

3.13.6 Non-Compliance

3.13.6.1 In the event of the MCO's noncompliance with the non-discrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated or suspended in whole or in part and the MCO may be declared ineligible for further government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24,

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1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.13.7 Changes in Law

3.13.7.1 The MCO shall implement appropriate program, policy or system changes, as required by changes to State and federal laws or regulations or interpretations thereof.

3.14 Subcontractors

3.14.1 MCO Obligations

3.14.1.1 The MCO shall maintain ultimate responsibility for adhering to, and otherwise fully complying with the terms and conditions of this Agreement, notwithstanding any relationship the MCO may have with the Subcontractor, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by the MCO.

3.14.1.2 For the purposes of this Agreement, such work performed by any Subcontractor shall be deemed performed by the MCO. [42 CFR 438.230(b)]

3.14.1.3 DHHS reserves the right to require the replacement of any Subcontractor or other contractor found by DHHS to be unacceptable or unable to meet the requirements of this Agreement, and to object to the selection or use of a Subcontractor or contract.

3.14.1.4 The MCO, regardless of its written agreements with any Subcontractors, maintains ultimate responsibility for complying with this Agreement.

3.14.1.5 The MCO shall have oversight of all Subcontractors' policies and procedures for compliance with the False Claims Act (FCA) and other State and federal laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

3.14.2 Contracts with Subcontractors

3.14.2.1 The MCO shall have a written agreement between the MCO and each Subcontractor which includes, but shall not be limited to:

3.14.2.1.1 All required activities and obligations of the Subcontractor and related reporting responsibilities and safeguarding of Confidential Information according to State rules, and State and federal laws;

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- 3.14.2.1.2 Full disclosure of the method and amount of compensation or other consideration received by the Subcontractor;
- 3.14.2.1.3 Amount, duration, and scope of services to be provided by the Subcontractor;
- 3.14.2.1.4 Term of the agreement, methods of extension, and termination rights;
- 3.14.2.1.5 The process to transition services when the agreement expires or terminates;
- 3.14.2.1.6 Information about the grievance and appeal system and the rights of the Member as described in 42 CFR 438.414 and 42 CFR 438.10(g);
- 3.14.2.1.7 Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement;
- 3.14.2.1.8 Requirements for the Subcontractor:
 - 3.14.2.1.8.1. To hold harmless DHHS and its employees, and all Members served under the terms of this Agreement in the event of non-payment by the MCO;
 - 3.14.2.1.8.2. To indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors;
- 3.14.2.1.9 Requirements that provide that:
 - 3.14.2.1.9.1. The MCO, DHHS, NH Medicaid Fraud Control Unit (MFCU), NH Department of Justice (DOJ), U.S. DOJ, the OIG, and the Comptroller General or their respective designees shall have the right to audit, evaluate, and inspect, and that it shall make available for the purpose of audit, evaluation or inspection, any premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of the services and/or activities performed or determination of amounts payable under

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this Agreement; [42 CFR 438.230(c)(3)(i) & (ii); 42 CFR 438.3(k)]

3.14.2.1.9.2. The Subcontractor shall further agree that it can be audited for ten (10) years from the final date of the Term or from the date of any completed audit, whichever is later; and [42 CFR 438.230(c)(3)(iii); 42 CFR 438.3(k)]

3.14.2.1.9.3. The MCO, DHHS, MFCU, NH DOJ, U.S. DOJ, OIG, and the Comptroller General or their respective designees may conduct an audit at any time if DHHS, MFCU, NH DOJ, U.S. DOJ, the OIG, and the Comptroller General or their respective designee determines that there is a reasonable possibility of fraud, potential Member harm or similar risk. [42 CFR 438.230(c)(3)(iv); 42 CFR 438.3(k)]

3.14.2.1.10 Subcontractor's agreement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority;

3.14.2.1.11 Require Subcontractor to submit ownership and controlling interest information as required by Section 3.10.3 (Ownership and Control Disclosures);

3.14.2.1.12 Require Subcontractors to investigate and disclose to the MCO, at contract execution or renewal, and upon request by the MCO of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid since the inception of those programs and who is [42 CFR 455.106(a)]:

3.14.2.1.12.1. A person who has an ownership or control interest in the Subcontractor or Participating Provider; [42 CFR 455.106(a)(1)]

3.14.2.1.12.2. An agent or person who has been delegated the authority to obligate or act on behalf of the Subcontractor or Participating Provider; or [42 CFR 455.101; 42 CFR 455.106(a)(1)]

3.14.2.1.12.3. An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the Subcontractor or

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Participating Provider [42 CFR 455.101; 42 CFR 455.106(a)(2)]

3.14.2.1.13 Require Subcontractor to screen its directors, officers, employees, contractors and Subcontractors against each of the Exclusion Lists on a monthly basis and report to the MCO any person or entity appearing on any of the Exclusion Lists and begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved waiver program;

3.14.2.1.14 Require Subcontractor to have a compliance plan that meets the requirements of 42 CFR Section 438.608 and policies and procedures that meet the Deficit Reduction Act (DRA) of 2005 requirements;

3.14.2.1.15 Prohibit Subcontractor from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories;

3.14.2.1.16 A provision for revoking delegation of activities or obligations, or imposing other sanctions if the Subcontractor's performance is determined to be unsatisfactory by the MCO or DHHS;

3.14.2.1.17 Subcontractor's agreement to comply with the ADA, as required by Section 3.13.4 (Americans with Disabilities Act) above;

3.14.2.1.18 Include provisions of this Section 3.14.2 (Contracts with Subcontractors) in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965;

3.14.2.1.19 Require any Subcontractor, to the extent that the Subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under this Agreement, to implement policies and procedures, as reviewed by DHHS, for reporting of all Overpayments identified, including embezzlement or receipt of Capitation Payments to which it was not entitled or recovered, specifying the Overpayments due to potential fraud, to the State.

3.14.2.1.20 Require any Subcontractor to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and Agreement provisions. [42 CFR 438.230(c)(2); 42 CFR 438.3(k)]

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3.14.2.1.21 Require any Subcontractor to comply with any other provisions specifically required under this Agreement or the applicable requirements of 42 CFR 438. [42 CFR 438.230]

3.14.2.2 The MCO shall notify DHHS in writing within one (1) business day of becoming aware that its Subcontractor is cited as non-compliant or deficient by any State or federal regulatory authority.

3.14.2.3 If any of the MCO's activities or obligations under this Agreement are delegated to a Subcontractor:

3.14.2.3.1 The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the MCO and the Subcontractor; and

3.14.2.3.2 The contract or written arrangement between the MCO and the Subcontractor shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the state or the MCO determines that the Subcontractor has not performed satisfactorily. [42 CFR 438.230(c)(1)(i) - (iii); 42 CFR 438.3(k)].

3.14.2.4 Subcontractors or any other party performing utilization review are required to be licensed in NH.

3.14.3 Notice and Approval

3.14.3.1 The MCO shall submit all Subcontractor agreements and Subcontractor Provider agreements to DHHS, for review at least sixty (60) calendar days prior to the anticipated implementation date of that Subcontractor agreement, any time there is a renewal or extension amendment to a Subcontractor agreement already reviewed by DHHS or there is a substantial change in scope or terms of the Subcontractor agreement.

3.14.3.2 The MCO remains responsible for ensuring that all Agreement requirements are met, including requirements requiring the integration of physical and behavioral health, and that the Subcontractor adheres to all State and federal laws, regulations and related guidance and guidelines.

3.14.3.3 The MCO shall notify DHHS of any change in Subcontractors and shall submit a new Subcontractor agreement for review sixty (60) calendar days prior to the start date of the new Subcontractor agreement.

3.14.3.4 Review by DHHS of a Subcontractor agreement does not relieve the MCO from any obligation or responsibility regarding the

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Subcontractor and does not imply any obligation by DHHS regarding the Subcontractor or Subcontractor agreement.

3.14.3.5 DHHS may grant a written exception to the notice requirements of this Section 3.14.3 (Notice and Approval) if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

3.14.3.6 The MCO shall notify DHHS within five (5) business days of receiving notice from a Subcontractor of its intent to terminate a Subcontractor agreement.

3.14.3.7 The MCO shall notify DHHS of any material breach by Subcontractor of an agreement between the MCO and the Subcontractor that may result in the MCO being non-compliant with or violating this Agreement within one (1) business day of validation that such breach has occurred.

3.14.3.8 The MCO shall take any actions directed by DHHS to cure or remediate said breach by the Subcontractor.

3.14.3.9 In the event of material change, breach or termination of a Subcontractor agreement between the MCO and a Subcontractor, the MCO's notice to DHHS shall include a transition plan for DHHS's review and approval.

3.14.4 MCO Oversight of Subcontractors

3.14.4.1 The MCO shall provide its Subcontractors with training materials regarding preventing fraud, waste and abuse and shall require the MCO's hotline to be publicized to Subcontractors' staff who provide services to the MCO.

3.14.4.2 The MCO shall oversee and be held accountable for any functions and responsibilities that it delegates to any Subcontractor in accordance with 42 CFR 438.230 and 42 CFR Section 438.3, including:

3.14.4.2.1 Prior to any delegation, the MCO shall evaluate the prospective Subcontractor's ability to perform the Social Security activities to be delegated;

3.14.4.2.2 The MCO shall audit the Subcontractor's compliance with its agreement with the MCO and the applicable terms of this Agreement, at least annually and when there is a substantial change in the scope or terms of the Subcontractor agreement; and

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3.14.4.2.3 The MCO shall identify deficiencies or areas for improvement, if any. The MCO shall prompt the Subcontractor to take corrective action.

3.14.4.3 The MCO shall develop and maintain a system for regular and periodic monitoring of each Subcontractor's compliance with the terms of its agreement and this Agreement.

3.14.4.4 If the MCO identifies deficiencies or areas for improvement in the Subcontractor's performance that affect compliance with this Agreement, the MCO shall notify DHHS within seven (7) calendar days and require the Subcontractor to develop a CAP. The MCO shall provide DHHS with a copy of the Subcontractor's CAP within thirty (30) calendar days upon DHHS request, which is subject to DHHS approval [42 CFR 438.230 and 42 CFR Section 438.3]

3.15 Staffing

3.15.1 **Key Personnel**

3.15.1.1 The MCO shall commit key personnel to the MCM program on a full-time basis. Positions considered to be key personnel, along with any specific requirements for each position, include:

3.15.1.1.1 CEO/Executive Director: Individual shall have clear authority over the general administration and day-to-day business activities of this Agreement.

3.15.1.1.2 Finance Officer: Individual shall be responsible for accounting and finance operations, including all audit activities.

3.15.1.1.3 Medical Director: Individual shall be a physician licensed by the NH Board of Medicine, shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of Covered Services to Members, developing clinical practice standards and clinical policies and procedures.

3.15.1.1.3.1. The Medical Director shall have substantial involvement in QAPI Program activities and shall attend monthly, or as otherwise requested, in-person meetings with the DHHS Medical Director.

3.15.1.1.3.2. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health).

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3.15.1.1.3.3. The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

3.15.1.1.4 Quality Improvement Director: Individual shall be responsible for all QAPI program activities.

3.15.1.1.4.1. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement meetings with DHHS and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.15.1.1.5 Compliance Officer: Individual shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement.

3.15.1.1.5.1. The Compliance Officer shall report directly to the NH-based CEO or the executive director thereof.

3.15.1.1.6 Network Management Director: Individual shall be responsible for development and maintenance of the MCO's Participating Provider network.

3.15.1.1.7 Provider Relations Manager: Individual shall be responsible for provision of all MCO Provider services activities.

3.15.1.1.7.1. The manager shall have prior experience with individual physicians, Provider groups and facilities.

3.15.1.1.8 Member Services Manager: Individual shall be responsible for provision of all MCO Member Services activities.

3.15.1.1.8.1. The manager shall have prior experience with Medicaid populations.

3.15.1.1.9 Utilization Management (UM) Director: Individual shall be responsible for all UM activities.

3.15.1.1.9.1. This person shall be under the direct supervision of the Medical Director and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services.

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3.15.1.1.9.2. The MCO shall also ensure that the UM program assigns responsibility to appropriately licensed clinicians, including a behavioral health and a LTSS professional for those respective services.

3.15.1.1.10 Systems Director/Manager: Individual shall be responsible for all MCO information systems supporting this Agreement, including but not limited to continuity and integrity of operations, continuity flow of records with DHHS's information systems and providing necessary and timely reports to DHHS.

3.15.1.1.11 Encounter Manager: Individual shall be responsible for and qualified by training and experience to oversee encounter submittal and processing to ensure the accuracy, timeliness, and completeness of encounter reporting.

3.15.1.1.12 Claims Manager: Individual shall be responsible for and qualified by training and experience to oversee claims processing and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

3.15.1.1.13 Pharmacy Manager: Individual shall be a pharmacist licensed by the NH Board of Pharmacy and shall have a minimum of five (5) years pharmacy experience as a practicing pharmacist.

3.15.1.1.13.1. The individual shall be responsible for all pharmacy activities, including but not limited to the Lock-In Program, coordinating clinical criteria for Prior Authorizations, compliance with the opioid prescribing requirements outlined in Section 4.11.6 (Substance Use Disorder) and overseeing the Drug Utilization Review (DUR) Board or the Pharmacy and Therapeutics Committee.

3.15.1.1.14 [Amendment #8:] Substance Use Disorder Physician: Effective July 1, 2022, individual shall be an Addiction Medicine Physician licensed by the NH Board of Medicine, and participate under the terms of this Agreement without regard to leeway previously granted by DHHS.

3.15.1.1.14.1. The individual shall be responsible for providing clinical oversight and guidance for the MCO on Substance Use Disorder issues, including issues such as the use of ASAM or other evidence-based assessments and treatment protocols, the use of MAT, engagements with PRSS, and discharge planning for

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Members who visit an ED or are hospitalized for an overdose.

3.15.1.1.14.2. The Substance Use Disorder Physician shall be available to the MCM program on a routine basis for consultations on MCO clinical policy related to Substance Use Disorders and the cases of individual Members, as needed.

3.15.1.2 Coordinators shall be responsible for overseeing Care Coordination and Care Management activities for MCO Members with complex medical, behavioral health, DD, and long term care needs; or for overseeing other activities.

3.15.1.3 Coordinators shall also serve as liaisons to DHHS staff for their respective functional areas. The MCO shall assign coordinators to each of the following areas on a full-time basis:

3.15.1.3.1 Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.15.1.3.1.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

3.15.1.3.1.2. The Special Needs Coordinator shall be responsible for ensuring compliance with and implementation of requirements for Adults and Children with Special Care Needs related to Care Management, Network Adequacy, access to Benefits, and Utilization Management.

3.15.1.3.1.3. [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ ~~2024~~, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions.

3.15.1.3.2 Developmental Disability Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

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3.15.1.3.2.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

3.15.1.3.2.2. The Developmental Disability Coordinator shall be responsible for ensuring coordination with LTSS Case Managers for Members enrolled in the MCO but who have services covered outside of the MCO's Covered Services.

3.15.1.3.2.3. [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ ~~2024~~, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions.

3.15.1.3.3 Mental Health Coordinator: Individual shall oversee the delivery of Mental Health Services to ensure that there is a single point of oversight and accountability.

3.15.1.3.3.1. Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.15.1.3.3.2. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within Community Mental Health Services.

3.15.1.3.3.3. Other key functions shall include coordinating Mental Health Services across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; implementation and interpretation of clinical

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policies and procedures; and Social Determinants of Health and community-based resources.

3.15.1.3.4 Substance Use Disorder Coordinator: Individual shall be an addiction medicine specialist on staff or under contract who works with the Substance Use Disorder Physician to provide clinical oversight and guidance to the MCO on Substance Use Disorder issues.

3.15.1.3.4.1. The Substance Use Disorder Coordinator shall be a Masters Licensed Alcohol and Drug Counselor (MLADC) or Licensed Mental Health Professional who is able to demonstrate experience in the treatment of Substance Use Disorder.

3.15.1.3.4.2. The individual shall have expertise in screening, assessments, treatment, and Recovery strategies; use of MAT; strategies for working with child welfare agencies, correctional institutions and other health and social service agencies that serve individuals with Substance Use Disorders.

3.15.1.3.4.3. The individual shall be available to the MCM program on a routine basis for consultations on clinical, policy and operational issues, as well as the disposition of individual cases.

3.15.1.3.4.4. Other key functions shall include coordinating Substance Use Disorder services and treatment across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; and social determinants of health and community-based resources.

3.15.1.3.5 Long Term Care Coordinator: Individual shall be responsible for coordinating managed care Covered Services with FFS and waiver programs.

3.15.1.3.5.1. The individual shall have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management

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responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care services.

3.15.1.3.5.2. [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ 2024, the Long Term Care Coordinator position is not required.

3.15.1.3.6 Grievance Coordinator: Individual shall be responsible for overseeing the MCO's Grievance System.

3.15.1.3.7 Fraud, Waste, and Abuse Coordinator: Individual shall be responsible for tracking, reviewing, monitoring, and reducing fraud, waste and abuse.

3.15.1.3.8 [Amendment #5:] Housing Coordinator: Except as described at Sections 3.15.1.3.8.7, 3.15.2.4.5, and 4.11.5.7.2.1, the individual shall be responsible for helping to identify, secure, and maintain community based housing for Members and developing, articulating, and implementing a broader housing strategy within the MCO to expand housing availability/options.

3.15.1.3.8.1. The Housing Coordinator shall act as the MCO's central housing expert/resource, providing education and assistance to all MCO's relevant staff (care managers and others) regarding supportive housing services and related issues.

3.15.1.3.8.2. The Housing Coordinator shall be a dedicated staff person whose primary responsibility is housing-related work.

3.15.1.3.8.3. The Housing Coordinator shall not be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO.

3.15.1.3.8.4. The Housing Coordinator shall act as a liaison with the Department's Bureau of Housing and Homeless Services to receive training and work in collaboration on capacity requirements/building.

3.15.1.3.8.5. The Housing Coordinator shall have at least two (2) year's full-time experience is assisting vulnerable populations to secure accessible, affordable housing.

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3.15.1.3.8.6. The Coordinator shall be familiar with the relevant public and private housing resources and stakeholders.

3.15.1.3.8.7. [~~Amendment #10:~~] [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ 2024, the Housing Coordinator position is not required.

3.15.1.3.9 Prior Authorization Coordinator: Individual shall be responsible for all MCO Utilization Management activities and shall work under the direct supervision of the Medical Director.

3.15.1.3.9.1. The Prior Authorization Coordinator shall ensure that all staff performing prior authorization functions have the necessary clinical backgrounds needed to apply established coverage criteria and make appropriate decisions based on medical necessary.

3.15.1.3.9.2. The individual shall be licensed by the NH Board of Nursing and have a minimum of eight (8) years of demonstrated experience in both the provision of direct clinical services as well as progressively increasing levels of management responsibilities with a particular focus on performance of a variety of utilization functions including conducting inter-rater reliability quality audits.

3.15.2 Other MCO Required Staff

3.15.2.1 Fraud, Waste, and Abuse Staff: The MCO shall establish a Special Investigations Unit (SIU), which shall be comprised of experienced fraud, waste and abuse investigators who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein.

3.15.2.1.1 At a minimum, the SIU shall have at least two (2) fraud, waste and abuse investigators and one (1) Fraud, Waste and Abuse Coordinator.

3.15.2.1.2 The MCO shall adequately staff the SIU to ensure that the MCO meets Agreement provisions of Section 5.3.2 (Fraud, Waste and Abuse).

3.15.2.2 Behavioral Health Clinical Providers to Minimize Psychiatric Boarding: The MCO shall supply a sufficient number of

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hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to, or at risk for, Psychiatric Boarding.

3.15.2.2.1 The number of such hospital-credentialed Providers shall be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed.

3.15.2.2.2 The initial on-site assistance provided within these required timelines shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or another Designated Receiving Facility.

3.15.2.2.3 Each such hospital-credentialed Provider shall have the clinical expertise to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources, that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required.

3.15.2.2.3.1. [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30, December 31, 2022~~ 2024, the Psychiatric Boarding program's hospital-credentialed Provider position(s) are not required.

3.15.2.3 [Amendment #8:] Staff for Members at New Hampshire Hospital: The MCO shall designate an off-site ~~on-site~~ liaison with privileges at New Hampshire Hospital to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process ~~for Members admitted to New Hampshire Hospital.~~

3.15.2.3.1 [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30, December 31, 2022~~ 2024, the Staff for Members at New Hampshire Hospital position is not required.

3.15.2.4 [Amendment #5:] Additional Behavioral Health Staff: Except as described at Sections 3.15.1.3.8.7, 3.15.2.4.5, and 4.11.5.7.2.1, the MCO shall designate one (1) or more staff who have behavioral health specific managed care experience to provide in-person housing ~~in-person housing~~ assistance to Members who are homeless and oversee:

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- 3.15.2.4.1 Behavioral health Care Management;
- 3.15.2.4.2 Behavioral health Utilization Management;
- 3.15.2.4.3 Behavioral health network development; and
- 3.15.2.4.4 The behavioral health Subcontract, as applicable.
- 3.15.2.4.5 [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ 2024, the Behavioral Health Staff position responsible for in-person housing assistance is not required.
- 3.15.2.5 Any subcontracted personnel or entity engaged in decision-making for the MCO regarding clinical policies related to Substance Use Disorder or mental health shall have demonstrated experience working in direct care for Members with Substance Use Disorder or mental health.
- 3.15.2.6 [Amendment #5:] ~~The crisis lines and~~ Emergency Services teams shall employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention calls and who have access to a clinician available to evaluate the Member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

3.15.3 On-Site Presence

- 3.15.3.1 The MCO shall have an on-site presence in New Hampshire. On-site presence for the purposes of this Section 3.15.3 of the Agreement means that the MCO's personnel identified below regularly reports to work in the State of New Hampshire:
 - 3.15.3.1.1 CEO/Executive Director;
 - 3.15.3.1.2 Medical Director;
 - 3.15.3.1.3 [Amendment #5:] Intentionally Left Blank ~~Quality Improvement Director;~~
 - 3.15.3.1.4 [Amendment #5:] Intentionally Left Blank ~~Compliance Officer;~~
 - 3.15.3.1.5 Network Management Director;
 - 3.15.3.1.6 Provider Relations Manager;
 - 3.15.3.1.7 [Amendment #5:] Intentionally Left Blank ~~Utilization Management Director;~~
 - 3.15.3.1.8 Pharmacy Manager;

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- 3.15.3.1.9 Substance Use Disorder Physician;
- 3.15.3.1.10 Special Needs Coordinator;
- 3.15.3.1.11 Mental Health Coordinator;
- 3.15.3.1.12 Substance Use Disorder Coordinator;
- 3.15.3.1.13 DD Coordinator;
- 3.15.3.1.14 Long Term Care Coordinator;
- 3.15.3.1.15 Housing Coordinator;
- 3.15.3.1.16 Grievance Coordinator;
- 3.15.3.1.17 Fraud, Waste, and Abuse Coordinator; and
- 3.15.3.1.18 [Amendment #5:] Intentionally Left Blank Prior Authorization Coordinator.

3.15.3.2 Upon DHHS's request, MCO required staff who are not located in New Hampshire shall travel to New Hampshire for in-person meetings.

3.15.3.3 The MCO shall provide to DHHS for review and approval key personnel and qualifications no later than sixty (60) calendar days prior to the start of the program.

3.15.3.4 The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by DHHS, which approval shall not be unreasonably withheld.

3.15.3.5 [Amendment #5:] DHHS may grant a written exception to the notice requirements of this section if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

3.15.4 General Staffing Provisions

3.15.4.1 The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely manner as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS may impose liquidated damages, in accordance with Section 5.5.2 (Liquidated Damages).

3.15.4.2 The MCO shall ensure that all staff receive appropriate training, education, experience, and orientation to fulfill the

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requirements of the positions they hold and shall verify and document that it has met this requirement.

3.15.4.2.1 This includes keeping up-to-date records and documentation of all individuals requiring licenses and/or certifications and such records shall be available for DHHS inspection.

3.15.4.3 All key personnel shall be generally available during DHHS hours of operation and available for in-person or video conferencing meetings as requested by DHHS.

3.15.4.3.1 The MCO key personnel, and others as required by DHHS, shall, at a minimum, be available for monthly in-person meetings in NH with DHHS.

3.15.4.4 The MCO shall make best efforts to notify DHHS at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel.

3.15.4.5 If a member of the MCO's key personnel is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform DHHS within seven (7) calendar days, and submit a transition plan with proposed alternate staff to DHHS for review and approval, for which approval shall not be unreasonably withheld.

3.15.4.5.1 The Staffing Transition Plan shall include, but is not limited to:

3.15.4.5.1.1. The allocation of resources to the Agreement during key personnel vacancy;

3.15.4.5.1.2. The timeframe for obtaining key personnel replacements within ninety (90) calendar days; and

3.15.4.5.1.3. The method for onboarding staff and bringing key personnel replacements/additions up-to-date regarding this Agreement.

4 PROGRAM REQUIREMENTS

4.1 Covered Populations and Services

4.1.1 Overview of Covered Populations

4.1.1.1 The MCO shall provide and be responsible for the cost of managed care services to population groups deemed by DHHS to be eligible for managed care and to be covered under the terms of this Agreement, as indicated in the table below.

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4.1.1.2 Members enrolled with the MCO who subsequently become ineligible for managed care during MCO enrollment shall be excluded from MCO participation. DHHS shall, based on State or federal statute, regulation, or policy, exclude other Members as appropriate.

Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Aid to the Needy Blind Non-Dual	X	
Aid to the Permanently and Totally Disabled Non-Dual	X	
American Indians and Alaskan Natives	X	
Auto Eligible and Assigned Newborns	X	
Breast and Cervical Cancer Program	X	
Children Enrolled in Special Medical Services/Partners in Health	X	
Children with Supplemental Security Income	X	
Family Planning Only Benefit		X
Foster Care/Adoption Subsidy	X	
Granite Advantage (Medicaid Expansion Adults, Frail/Non-Frail)	X	
Health Insurance Premium Payment		X
Home Care for Children with Severe Disabilities (Katie Beckett)	X	
In and Out Spend-Down		X
Medicaid Children Funded through the Children's Health Insurance Program	X	

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Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Medicaid for Employed Adults with Disabilities Non-Dual	X	
<u>[Amendment #5:] Medicaid for Employed Older Adults with Disabilities</u>	X	
Medicare Duals with full Medicaid Benefits	X	
Medicare Savings Program Only (no Medicaid services)		X
Members with Veterans Affairs Benefits		X
Non-Expansion Poverty Level Adults (Including Pregnant Women) and Children Non-Dual	X	
Old Age Assistance Non-Dual	X	
Retroactive/Presumptive Eligibility Segments (excluding Auto Eligible Newborns)		X
Third Party Coverage Non-Medicare, Except Members with Veterans Affairs Benefits	X	

4.1.2 Overview of Covered Services

4.1.2.1 The MCO shall cover the physical health, behavioral health, pharmacy, and other benefits for all MCO Members, as indicated in the summary table below and described in this Agreement. Additional requirements for Behavioral Health Services are included in Section 4.11 (Behavioral Health), and additional requirements for pharmacy are included in Section 4.2 (Pharmacy Management).

4.1.2.2 The MCO shall provide, at a minimum, all services identified in the following matrix, and all services in accordance with the CMS-approved Medicaid State Plan and Alternative Benefit Plan State Plan. The MCO shall cover services consistent with 45 CFR 92.207(b).

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4.1.2.3 While the MCO may provide a higher level of service and cover more services than required by DHHS (as described in Section 4.1.3 (Covered Services Additional Provisions), the MCO shall, at a minimum, cover the services identified at least up to the limits described in NH Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. DHHS reserves the right to alter this list at any time by providing reasonable notice to the MCO. [42 CFR 438.210(a)(1) and (2)]

4.1.2.3.1 [Amendment #6:] Covered home visiting services shall be consistent with State regulatory rules in effect.

Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Acquired Brain Disorder Waiver Services		X
Adult Medical Day Care	X	
Advanced Practice Registered Nurse	X	
Ambulance Service	X	
Ambulatory Surgical Center	X	
Audiology Services	X	
[Amendment #7] Intentionally Left Blank - Behavioral Health Crisis Treatment Center⁸	X	
Certified Non-Nurse Midwife	X	
Choices for Independence Waiver Services		X
Child Health Support Service – Division for Children, Youth & Families, except for services eligible under EPSDT		X

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Community Mental Health Services ⁹	X	
Crisis Intervention – Division for Children, Youth & Families		X
Developmental Disability Waiver Services		X
Dental Benefit Services ¹⁰		X
Designated Receiving Facilities	X	
Developmental Services Early Supports and Services		X
Early and Periodic Screening, Diagnostic and Treatment Services including Applied Behavioral Analysis Coverage	X	
Family Planning Services	X	
Freestanding Birth Centers	X	
Furnished Medical Supplies & Durable Medical Equipment	X	
Glenclyff Home		X
Home Based Therapy – Division for Children, Youth & Families		X
Home Health Services	X	
Home Visiting Services	X	

⁹ [Amendment #10] [Amendment #9] [Amendment #8:] [Amendment #7:] For the period July 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30, December 31, 2022~~, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

¹⁰ [Amendment #10:] Effective April 1, 2023, certain preventive, restorative, denture and other oral health services are carved-out of the MCM Program and covered under the State's contract with Delta Dental of New Hampshire, Inc. for eligible adults ages 21 years and over. Dental and oral health emergency services for Medicaid enrolled children and adults of all ages will continue to be Covered Services under the MCM Program.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Hospice	X	
Home and Community-Based In Home Support Services		X
Inpatient Hospital	X	
Inpatient Hospital Swing Beds, Intermediate Care Facility		X
Inpatient Hospital Swing Beds, Skilled Nursing Facility		X
Inpatient Psychiatric Facility Services Under Age Twenty-One (21) ¹¹	X	
[Amendment #9:] [Amendment #8:] Inpatient Psychiatric Treatment in State-owned New Hampshire Hospital and Hampstead Hospital, and Other State Determined IMD for Mental Illness Inpatient Psychiatric Treatment in an Institution for Mental Disease, excluding New Hampshire Hospital¹²	X	
Intensive Home and Community-Based Services– Division for Children, Youth & Families		X
Intermediate Care Facility Atypical Care		X
Intermediate Care Facility for Members with Intellectual Disabilities ¹³		X
Intermediate Care Facility Nursing Home		X
Laboratory (Pathology)	X	
Medicaid to Schools Services		X
Medical Services Clinic (e.g. Opioid Treatment Program)	X	

¹¹ Under age 22 if individual admitted prior to age 21

¹² [Amendment #9:] [Amendment #8:] Beginning July 1, 2022, Medicaid managed care inpatient psychiatric treatment at State-owned New Hampshire Hospital and Hampstead Hospital, and other State determined IMD for mental illness is covered up to sixty (60) days for adults age 21-64 due to a primary diagnosis of mental illness. Pursuant to 42 CFR 438.6 and 42 CFR 438.3(e)(2)(i) through (iii)

¹³ E.g., Cedarcrest

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Services	'MCO Covered'	Not Included in Managed Care (DHHS Covered)
Non-Emergency Medical Transportation ¹⁴	X	
Occupational Therapy ¹⁵	X	
Optometric Services Eyeglasses	X	
Outpatient Hospital ¹⁶	X	
<u>[Amendment #8:] Pediatric Residential Treatment Facility Services (effective September 1, 2019)</u>		X
Personal Care Services	X	
Physical Therapy ¹⁷	X	
Physicians Services	X	
Placement Services – Division for Children, Youth & Families		X
Podiatrist Services	X	
Prescribed Drugs	X	
Private Duty Nursing	X	
Private Non-Medical Institutional For Children – Division for Children, Youth & Families		X
Psychology	X	
<u>[Amendment #8:] Qualified Residential Treatment Program Services (effective September 1, 2019)</u>		X
Rehabilitative Services Post Hospital Discharge	X	

¹⁴ Also includes mileage reimbursement for Medically Necessary travel

¹⁵ Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services

¹⁶ Including facility and ancillary services for dental procedures

¹⁷ Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Rural Health Clinic & Federally Qualified Health Centers	X	
Non-Swing Bed Skilled Nursing Facilities		X
Skilled Nursing Facilities Skilled Nursing Facilities Atypical Care		X
Speech Therapy ¹⁸	X	
Substance Use Disorder Services (Per He-W 513) – including services provided in Institutions for Mental Diseases pursuant to an approved 1115(a) research and demonstration waiver	X	
Transitional Housing Program Services and Community Residential Services With Wrap-Around Services and Supports ¹⁹	X	
Wheelchair Van	X	
X-Ray Services	X	

4.1.3 Covered Services Additional Provisions

4.1.3.1 Nothing in this Section 4.1.3 shall be construed to limit the MCO's ability to otherwise voluntarily provide any other services in addition to the services required to be provided under this Agreement.

4.1.3.2 The MCO shall seek written approval from DHHS, bear the entire cost of the service, and the utilization and cost of such voluntary services shall not be included in determining payment rates.

4.1.3.3 All services shall be provided in accordance with 42 CFR 438.210 and 42 CFR 438.207(b). The MCO shall ensure there is no disruption in service delivery to Members or Providers as the MCO transitions these services into Medicaid managed care from FFS.

¹⁸ Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services
¹⁹ [Amendment #6:] Beginning no earlier than Amendment #7 [Amendment #4:] Beginning on July 1, 2021 [Amendment #2:] July 1, 2020. [Base Contract:] Beginning on January 1, 2020.

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4.1.3.4 The MCO shall adopt written policies and procedures to verify that services are actually provided. [42 CFR 455.1(a)(2)]

4.1.3.5 In Lieu Of Services

4.1.3.5.1 [Amendment #10:] The MCO may provide Members with services or settings that are "In Lieu Of" Services or settings with prior approval and in accordance with federal regulations included in the Medicaid State Plan that are more medically appropriate, cost effective substitutes for the Medicaid State Plan services. The MCO may cover In Lieu Of Services if:

4.1.3.5.1.1. Intentionally left blank DHHS determines that the alternative service or setting is a medically appropriate and cost effective substitute;

4.1.3.5.1.2. Intentionally left blank The Member is not required to use the alternative service or setting;

4.1.3.5.1.3. Intentionally left blank The In Lieu Of Service has been authorized by DHHS; and

4.1.3.5.1.4. Intentionally left blank The in Lieu Of Service has been offered to Members at the option of the MCO. [42 CFR 438.3(e)(2)(i) - (iii)]

4.1.3.5.1.5. [Amendment #10:] Any In Lieu of Services on record prior to January 3, 2023 and proposed for continuation must comply with CMS federal regulations beginning January 1, 2024. [42 CFR 438.3(e)(2)(i) - (iii); SMDL 1/4/23]

4.1.3.5.2 [Amendment #10:] Intentionally left blank DHHS may determine that the alternative service or setting is a medically appropriate and cost effective substitute by either: prospectively providing to the MCO a list of services that the MCO may consider In Lieu Of Services; or by the MCO receiving approval from DHHS to implement an In Lieu Of Service.

4.1.3.5.3 [Amendment #10:] Beginning September 1, 2019, DHHS has authorized medical nutrition, diabetes self-management, and assistance in finding and keeping housing (not including rent), as In Lieu Of Services. This list may be expanded upon or otherwise modified by DHHS through amendments of this Agreement. Previously authorized In Lieu Of Services are scheduled for review and modification as may be necessary to meet federal regulatory compliance effective January 1, 2024.

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4.1.3.5.4 [Amendment #10:] Intentionally left blank~~For the MCO to obtain approval for In Lieu Of Services not authorized by DHHS, the MCO shall submit an In Lieu Of Service request to DHHS for each proposed In Lieu of Service not yet authorized.~~

4.1.3.5.5 [Amendment #10:] The MCO shall support In Lieu of Services reporting~~monitor the cost effectiveness of each approved In Lieu of Service by tracking utilization and expenditures and submit an annual update providing an evaluation of the cost effectiveness of the alternative service during the previous twelve (12) months, in accordance with federal regulations and Exhibit O.~~

4.1.3.6 [Amendment #8:] Intentionally Left Blank ~~Institution for Mental Diseases (IMD)~~

4.1.3.6.1 [Amendment #8:] Intentionally left blank. Pursuant to 42 CFR 438.6, the MCO shall pay for up to fifteen (15) inpatient days per calendar month for any Member who is receiving treatment in an IMD that is not a state owned or operated facility for the primary treatment of a psychiatric disorder.

4.1.3.6.2 [Amendment #8:] Intentionally left blank: ~~The MCO shall not pay for any days in a given month if the Member exceeds fifteen (15) inpatient days for that month in an IMD that is not a state owned or operated facility, unless otherwise indicated by DHHS and permitted as a result of a federal waiver or other authority. The provision of inpatient psychiatric treatment in an IMD shall meet the requirements for In Lieu of Services at 42 CFR 438.3(e)(2)(i)-(iii).~~

4.1.3.7 Telemedicine

4.1.3.7.1 The MCO shall comply with provisions of RSA 167:4(d) by providing access to telemedicine services to Members in certain circumstances.

4.1.3.7.2 The MCO shall develop a telemedicine clinical coverage policy and submit the policy to DHHS for review. Covered telemedicine modalities shall comply with all local, State and federal laws including the HIPAA and record retention requirements.

4.1.3.7.3 The clinical policy shall demonstrate how each covered telemedicine modality ensures security of PHI, including data security and encryption policies.

4.1.3.8 Non-Participating Indian Health Care Providers

4.1.3.8.1 American Indian/Alaska Native Members are permitted to obtain Covered Services from Non-Participating Indian Health

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Care Providers (IHCP) from whom the Member is otherwise eligible to receive such services. [42 CFR 438.14(b)(4)]

4.1.3.8.2 The MCO shall permit any American Indian/Alaska Native Member who is eligible to receive services from an IHCP PCP that is a Participating Provider, to choose that IHCP as their PCP, as long as that Provider has capacity to provide the services. [American Reinvestment and Recovery Act 5006(d); SMDL 10-001; 42 CFR 438.14(b)(3)]

4.1.3.9 Moral and Religious Grounds

4.1.3.9.1 An MCO that would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(a)(2)]

4.1.3.9.2 If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the MCO shall furnish information about the services it does not cover to DHHS with its application for a Medicaid contract and any time thereafter when it adopts such a policy during the Term of this Agreement. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(b)(1)(i)(A)(1)-(2)]

4.1.3.9.3 If the MCO does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information on how and where to obtain such services, DHHS shall provide that information to potential Members upon request. [42 CFR 438.10(e)(2)(v)(C)]

4.1.4 Cost Sharing

4.1.4.1 Any cost sharing imposed on Medicaid Members shall be in accordance with NH's Medicaid Cost Sharing State Plan Amendment and Medicaid FFS requirements pursuant to 42 CFR 447.50 through 42 CFR 447.82. [Sections 1916(a)(2)(D) and 1916(b)(2)(D) of the Social Security Act; 42 CFR 438.108; 42 CFR 447.50 - 82; SMDL 6/16/06]

4.1.4.2 With the exception of Members who are exempt from cost sharing as described in the Medicaid Cost Sharing State Plan Amendment, the MCO shall require point of service (POS) Copayment for services for Members deemed by DHHS to have annual incomes at or above one hundred percent (100%) of the FPL as follows:

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4.1.4.2.1 A Copayment of one dollar (\$1.00) shall be required for each preferred prescription drug and each refill of a preferred prescription drug;

4.1.4.2.2 A Copayment of two dollars (\$2.00) shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug, unless the prescribing Provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the Copay for the non-preferred drug shall be one dollar (\$1.00);

4.1.4.2.3 A Copayment of one dollar (\$1.00) shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug; and

4.1.4.3 The following services are exempt from co-payments:

4.1.4.3.1 emergency services,

4.1.4.3.2 family planning services,

4.1.4.3.3 preventive services provided to children,

4.1.4.3.4 pregnancy-related services,

4.1.4.3.5 services resulting from potentially preventable events, and,

4.1.4.3.6 Cloramil (Clozapine) prescriptions. [42 CFR 447.56(a)]

4.1.4.4 Members are exempt from Copayments when:

4.1.4.4.1 The Member falls under the designated income threshold (one hundred percent (100%) or below the FPL);

4.1.4.4.2 The Member is under eighteen (18) years of age;

4.1.4.4.3 The Member is in a nursing facility or in an ICF for Members with IDs;

4.1.4.4.4 The Member participates in one (1) of the HCBS waiver programs;

4.1.4.4.5 The Member is pregnant and receiving services related to their pregnancy or any other medical condition that might complicate the pregnancy;

4.1.4.4.6 The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within sixty (60) calendar days after the month the pregnancy ended;

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4.1.4.4.7 The Member is in the Breast and Cervical Cancer Treatment Program;

4.1.4.4.8 The Member is receiving hospice care; or

4.1.4.4.9 The Member is an American Indian/Alaska Native.

4.1.4.5 Any American Indian/Alaskan Native who has ever received or is currently receiving an item or service furnished by an IHCP or through referral under contract health services shall be exempt from all cost sharing including Copayments and Premiums. [42 CFR 447.52(h); 42 CFR 447.56(a)(1)(x); ARRA 5006(a); 42 CFR 447.51(a)(2); SMDL 10-001]

4.1.5 Emergency Services

4.1.5.1 The MCO shall cover and pay for Emergency Services at rates that are no less than the equivalent DHHS FFS rates if the Provider that furnishes the services has an agreement with the MCO. [Section 1852(d)(2) of the Social Security Act; 42 CFR 438.114(b); 42 CFR 422.113(c)]

4.1.5.2 If the Provider that furnishes the Emergency Services does not have an agreement with the MCO, the MCO shall cover and pay for the Emergency Services in compliance with Section 1932(b)(2)(D) of the Social Security Act, 42 CFR 438.114(c)(1)(i), and the SMDL 3/20/98.

4.1.5.3 The MCO shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Participating Provider.

4.1.5.4 The MCO shall pay Non-Participating Providers of Emergency and Post-Stabilization Services an amount no more than the amount that would have been paid under the DHHS FFS system in place at the time the service was provided. [SMDL 3/31/06; Section 1932(b)(2)(D) of the Social Security Act]

4.1.5.5 The MCO shall not deny treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of Emergency Medical Condition.

4.1.5.6 The MCO shall not deny payment for treatment obtained when a representative, such as a Participating Provider, or the MCO instructs the Member to seek Emergency Services [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A) - (B)].

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4.1.5.7 The MCO shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

4.1.5.8 The MCO shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP, MCO, or DHHS of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. [42 CFR 438.114(d)(1)(i) - (ii)]

4.1.5.9 The MCO may not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. [42 CFR 438.114(d)(2)]

4.1.5.10 The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment. [42 CFR 438.114(d)(3)]

4.1.6 Post-Stabilization Services

4.1.6.1 Post-Stabilization Services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for Post-Stabilization Services:

4.1.6.1.1 Obtained within or outside the MCO that are pre-approved by a Participating Provider or other MCO representative;

4.1.6.1.2 Obtained within or outside the MCO that are not pre-approved by a Participating Provider or other MCO representative, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services; and/or

4.1.6.1.3 Administered to maintain, improve or resolve the Member's stabilized condition without pre-authorization, and regardless of whether the Member obtains the services within the MCO network if:

4.1.6.1.3.1 The MCO does not respond to a request for pre-approval within one (1) hour;

4.1.6.1.3.2 The MCO cannot be contacted; or

4.1.6.1.3.3 The MCO representative and the treating physician cannot reach an agreement concerning the Member's care and an MCO physician is

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not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with an MCO physician, and the treating physician may continue with care of the patient until an MCO physician is reached or one (1) of the criteria of 42 CFR 422.133(c)(3) is met. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)-(ii); 422.113(c)(2)(iii)(A)-(C)]

4.1.6.2 The MCO shall limit charges to Members for Post-Stabilization Services to an amount no greater than what the organization would charge the Member if the Member had obtained the services through the MCO. [[42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)]

4.1.6.3 The MCO's financial responsibility for Post-Stabilization Services, if not pre-approved, ends when:

4.1.6.3.1 The MCO physician with privileges at the treating hospital assumes responsibility for the Member's care;

4.1.6.3.2 The MCO physician assumes responsibility for the Member's care through transfer;

4.1.6.3.3 The MCO representative and the treating physician reach an agreement concerning the Member's care; or

4.1.6.3.4 The Member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i) - (iv)]

4.1.7 Value-Added Services

4.1.7.1 The MCO may elect to offer Value-Added Services that are not covered in the Medicaid State Plan or under this Agreement in order to improve health outcomes, the quality of care, or reduce costs, in compliance with 42 CFR 438.3(e)(i).

4.1.7.2 Value-Added Services are services that are not currently provided under the Medicaid State Plan. The MCO may elect to add Value-Added Services not specified in the Agreement at the MCO's discretion, but the cost of these Value-Added Services shall not be included in Capitation Payment calculations. The MCO shall submit to DHHS an annual list of the Value-Added Services being provided.

4.1.8 Early and Periodic Screening, Diagnostic, and Treatment

4.1.8.1 The MCO shall provide the full range of preventive, screening, diagnostic and treatment services including all medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions for EPSDT eligible beneficiaries ages

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birth to twenty-one in accordance with 1905(r) of the Social Security Act. [42 CFR 438.210(a)(5)]

4.1.8.2 The MCO shall determine whether a service is Medically Necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. Section 1396d(r), 42 CFR 438.210, and 42 CFR Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21, and the particular needs of the child and consistent with the definition for Medical Necessity included in this Agreement.

4.1.8.3 Upon conclusion of an individualized review of medical necessity, the MCO shall cover all Medically Necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. Section 1396d(a), regardless of whether such services are covered under the Medicaid State Plan and regardless of whether the request is labeled as such, with the exception of all services excluded from the MCO.

4.1.8.4 The MCO may provide Medically Necessary services in the most economic mode possible, as long as:

4.1.8.4.1 The treatment made available is similarly efficacious to the service requested by the Member's physician, therapist, or other licensed practitioner;

4.1.8.4.2 The determination process does not delay the delivery of the needed service; and

4.1.8.4.3 The determination does not limit the Member's right to a free choice of Participating Providers within the MCO's network.

4.1.8.5 Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services same day, or location of service) in the MCO clinical coverage policies, service definitions, or billing codes do not apply to Medicaid Members less than twenty-one (21) years of age, when those services are determined to be Medically Necessary per federal EPSDT criteria.

4.1.8.6 If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved per EPSDT criteria as Medically Necessary to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.

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4.1.8.7 The MCO shall not require Prior Authorization for Non-Symptomatic Office Visits (early and periodic screens/wellness visits) for Members less than twenty-one (21) years of age. The MCO may require Prior Authorization for other diagnostic and treatment products and services provided under EPSDT.

4.1.8.8 The MCO shall conduct Prior Authorization reviews using current clinical documentation, and shall consider the individual clinical condition and health needs of the child Member. The MCO shall not make an adverse benefit determination on a service authorization request for a Member less than twenty-one (21) years of age until the request is reviewed per EPSDT criteria.

4.1.8.9 While an EPSDT request is under review, the MCO may suggest alternative services that may be better suited to meet the Member's needs, engage in clinical or educational discussions with Members or Providers, or engage in informal attempts to resolve Member concerns as long as the MCO makes clear that the Member has the right to request authorization of the services he or she wants to request.

4.1.8.10 The MCO shall develop effective methods to ensure that Members less than twenty-one (21) years of age receive all elements of preventive health screenings recommended by the AAP in the Academy's most currently published Bright Futures preventive pediatric health care periodicity schedule using a validated screening tool. The MCO shall be responsible for requiring in contracts that all Participating Providers that are PCPs perform such screenings.

4.1.8.11 The MCO shall require that PCPs that are Participating Providers include all the following components in each medical screening:

4.1.8.11.1 Comprehensive health and developmental history that assesses for both physical and mental health, as well as for Substance Use Disorders;

4.1.8.11.2 Screening for developmental delay at each visit through the fifth (5th) year using a validated screening tool;

4.1.8.11.3 Screening for Autism Spectrum Disorders per AAP guidelines;

4.1.8.11.4 Comprehensive, unclothed physical examination;

4.1.8.11.5 All appropriate immunizations, in accordance with the schedule for pediatric vaccines, laboratory testing (including blood lead screening appropriate for age and risk factors); and

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4.1.8.11.6 Health education and anticipatory guidance for both the child and caregiver.

4.1.8.12 The MCO shall include the following information related to EPSDT in the Member Handbook:

4.1.8.12.1 The benefits of preventive health care;

4.1.8.12.2 Services available under the EPSDT program and where and how to obtain those services;

4.1.8.12.3 That EPSDT services are not subject to cost-sharing; and

4.1.8.12.4 That the MCO shall provide scheduling and transportation assistance for EPSDT services upon request by the Member.

4.1.8.13 The MCO shall perform outreach to Members who are due or overdue for an EPSDT screening service on a monthly basis.

4.1.8.13.1 The MCO shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed as a result of conditions disclosed during screenings and diagnosis.

4.1.8.14 The MCO shall submit its EPSDT plan for DHHS review and approval as part of its Readiness Review and in accordance with Exhibit O.

4.1.9 Non-Emergency Medical Transportation (NEMT)

4.1.9.1 The MCO shall arrange for the NEMT of its Members to ensure Members receive Medically Necessary care and services covered by the Medicaid State Plan regardless of whether those Medically Necessary Services are covered by the MCO.

4.1.9.1.1 [Amendment #10:] [Amendment #7:] For the federal COVID-19 Public Health Emergency period beginning March 18, 2020, The MCO shall assume medical necessity for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility.

4.1.9.2 The MCO shall provide the most cost-effective and least expensive mode of transportation to its Members. However, the MCO shall ensure that a Member's lack of personal transportation is not a barrier of accessing care. The MCO and/or any Subcontractors shall be required to comply with all of the NEMT Medicaid State Plan requirements.

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4.1.9.3 The MCO shall ensure that its Members utilize a Family and Friends Mileage Reimbursement Program if they have a car, or a friend or family member with a car, who can drive them to their Medically Necessary service. A Member with a car who does not want to enroll in the Family and Friends Program shall meet one (1) of the following criteria to qualify for transportation services:

4.1.9.3.1 Does not have a valid driver's license;

4.1.9.3.2 Does not have a working vehicle available in the household;

4.1.9.3.3 Is unable to travel or wait for services alone; or

4.1.9.3.4 Has a physical, cognitive, mental or developmental limitation.

4.1.9.4 The MCO shall make good faith effort to achieve a fifty percent (50%) rate of total NEMT one-way rides provided by the MCO through the Family and Friends Mileage Reimbursement Program.

4.1.9.4.1 [Amendment #9:] Effective January 1, 2023, plus an additional ninety (90) day ramp up period to allow for related Member and vendor communications, the Family and Friends mileage reimbursement rate will increase to 62.5 cents per mile. The rate is based on the Internal Revenue Service (IRS) defined standard mileage rate effective on July 1, 2022.

4.1.9.5 If no car is owned or available, the Member shall use public transportation if:

4.1.9.5.1 The Member lives less than one half mile from a bus route;

4.1.9.5.2 The Provider is less than one half mile from the bus route; and

4.1.9.5.3 The Member is an adult under the age of sixty-five (65).

4.1.9.6 Exceptions the above public transportation requirement are:

4.1.9.6.1 The Member has two (2) or more children under age six (6) who shall travel with the parent;

4.1.9.6.2 The Member has one (1) or more children over age six (6) who has limited mobility and shall accompany the parent to the appointment; or

4.1.9.6.3 The Member has at least one (1) of the following conditions:

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- 4.1.9.6.3.1. Pregnant or up to six (6) weeks post-partum,
- 4.1.9.6.3.2. Moderate to severe respiratory condition with or without an oxygen dependency,
- 4.1.9.6.3.3. Limited mobility (walker, cane, wheelchair, amputee, etc.),
- 4.1.9.6.3.4. Visually impaired,
- 4.1.9.6.3.5. Developmentally delayed,
- 4.1.9.6.3.6. Significant and incapacitating degree of mental illness, or
- 4.1.9.6.3.7. Other exception by Provider approval only.

4.1.9.7 If public transportation is not an option, the MCO shall ensure that the Member is provided transportation from a transportation Subcontractor.

4.1.9.7.1 [Amendment #7:] For NEMT driver services delivered on or after December 21, 2021, excluding public transit drivers, the MCO shall ensure: ~~The MCO shall be required to perform background checks on all non-emergency medical transportation providers and/or Subcontractors.~~

4.1.9.7.1.1. [Amendment #7:] Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

4.1.9.7.1.2. [Amendment #7:] Each such individual driver has a valid driver's license;

4.1.9.7.1.3. [Amendment #7:] Each such provider has in place a process to address any violation of a state drug law; and

4.1.9.7.1.4. [Amendment #7:] Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider. [Consolidated Appropriations Act, 2021 (Public Law 116-260), Division CC, Title II, Section 209].

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4.1.9.8 The MCO shall assure that ninety-five percent (95%) of all Member scheduled rides for non-methadone services are delivered within fifteen (15) minutes of the scheduled pick-up time.

4.1.9.9 The MCO shall provide reports to DHHS related to NEMT requests, authorizations, trip results, service use, late rides, and cancellations, in accordance with Exhibit O.

4.2 Pharmacy Management

4.2.1 MCO and DHHS Covered Prescription Drugs

4.2.1.1 The MCO shall cover all outpatient drugs where the manufacturer has entered into the federal rebate agreement and for which DHHS provides coverage as defined in Section 1927(k)(2) of the Social Security Act [42 CFR 438.3(s)(1)], with the exception of select drugs for which DHHS shall provide coverage to ensure Member access as identified by DHHS in separate guidance. The MCO shall not include drugs by manufacturers not participating in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) Medicaid rebate program on the MCO formulary without DHHS consent.

4.2.1.2 The MCO shall pay for all prescription drugs – including specialty and office administered drugs, with the exception of those specifically indicated by DHHS as not covered by the MCO in separate guidance – consistent with the MCO's formulary and pharmacy edits and Prior Authorization criteria that have been reviewed and approved by DHHS, and are consistent with the DHHS Preferred Drug List (PDL) as described in Section 4.2.2 (MCO Formulary) below.

4.2.1.3 Current Food and Drug Administration (FDA)-approved specialty, bio-similar and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO, unless such drugs are specified in DHHS guidance as covered by DHHS.

4.2.1.4 The MCO shall pay for, when Medically Necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a "compassionate-use basis" and imported from a foreign country.

4.2.1.5 [Amendment #7:] Effective no later than April 1, 2022, the MCO shall ensure Members diagnosed with opioid use disorder, substance use disorder, and behavioral health conditions treated at CMH Program, FQHC, FQHC look-alike, and Doorway network

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facilities with integrated on-site pharmacies have immediate access to covered specialty drugs to treat related conditions.

4.2.2 MCO Formulary

4.2.2.1 DHHS shall establish the PDL and shall be the sole party responsible for negotiating rebates for drugs on the PDL.

4.2.2.2 The MCO shall use DHHS's PDL and shall not negotiate any drug rebates with pharmaceutical manufacturers for prescribed drugs on the PDL.

4.2.2.3 DHHS shall be responsible for invoicing any pharmaceutical manufacturers for federal rebates mandated under federal law and for PDL supplemental rebates negotiated by DHHS.

4.2.2.4 The MCO shall develop a formulary that adheres to DHHS's PDL for drug classes included in the PDL and is consistent with Section 4.2.1 (MCO and DHHS Covered Prescription Drugs). In the event that DHHS makes changes to the PDL, DHHS shall notify the MCO of the change and provide the MCO with 30 calendar days to implement the change.

4.2.2.5 Negative changes shall apply to new starts within thirty (30) calendar days of notice from DHHS. The MCO shall have ninety (90) calendar days to notify Members and prescribers currently utilizing medications that are to be removed from the PDL if current utilization is to be transitioned to a preferred alternative.

4.2.2.6 For any drug classes not included in the DHHS PDL, the MCO shall determine the placement on its formulary of products within that drug class, provided the MCO covers all products for which a federal manufacturer rebate is in place and the MCO is in compliance with all DHHS requirements in this Agreement.

4.2.2.7 DHHS shall maintain a uniform review and approval process through which the MCO may submit additional information and/or requests for the inclusion of additional drug or drug classes on the DHHS PDL. DHHS shall invite the MCO's Pharmacy Manager to attend meetings of the NH Medicaid DUR Board.

4.2.2.8 The MCO shall make an up-to-date version of its formulary available to all Participating Providers and Members through the MCO's website and electronic prescribing tools. The formulary shall be available to Members and Participating Providers electronically, in a machine-readable file and format, and shall, at minimum, contain information related to:

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4.2.2.8.1 Which medications are covered, including whether it is the generic and/or the brand drug; and

4.2.2.8.2 What tier each medication is on. [42 CFR 438.10(i)(1) - (3)]

4.2.2.9 The MCO shall adhere to all relevant State and federal law, including without limitation, with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, laws of 2004, Senate Bill 383-FN, Sect. IVa. A Member shall continue to be treated or, if newly diagnosed, may be treated with a non-preferred drug based on any one (1) of the following criteria:

4.2.2.9.1 Allergy to all medications within the same class on the PDL;

4.2.2.9.2 Contraindication to or drug-to-drug interaction with all medications within the same class on the PDL;

4.2.2.9.3 History of unacceptable or toxic side effects to all medications within the same class on the PDL;

4.2.2.9.4 Therapeutic failure of all medications within the same class on the PDL;

4.2.2.9.5 An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal FDA-approved indication;

4.2.2.9.6 An age-specific indication;

4.2.2.9.7 Medical co-morbidity or other medical complication that precludes the use of a preferred drug; or;

4.2.2.9.8 Clinically unacceptable risk with a change in therapy to a preferred drug. Selection by the physician of the criteria under this subparagraph shall require an automatic approval by the pharmacy benefit program.

4.2.3 Clinical Policies and Prior Authorizations

4.2.3.1 The MCO, including any pharmacy Subcontractors, shall establish a pharmacy Prior Authorization program that includes Prior Authorization criteria and other POS edits (such as prospective DUR edits and dosage limits), and complies with Section 1927(d)(5) of the Social Security Act [42 CFR 438.3(s)(6)] and any other applicable State and federal laws, including House Bill 517, as further described in Section 4.11.1.15 (Prior Authorization).

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4.2.3.2 The MCO's pharmacy Prior Authorization criteria, including any pharmacy policies and programs, shall be submitted to DHHS prior to the implementation of this Agreement, shall be subject to DHHS approval, and shall be submitted to DHHS prior to the MCO's implementation of a modification to the criteria, policies, and/or programs.

4.2.3.3 The MCO's pharmacy Prior Authorization criteria shall meet the requirements related to Substance Use Disorder, as outlined in Section 4.11.6.15 (Limitations on Prior Authorization Requirements) of this Agreement. Under no circumstances shall the MCO's Prior Authorization criteria and other POS edits or policies depart from these requirements.

4.2.3.3.1 Additionally, specific to Substance Use Disorder, the MCO shall offer a pharmacy mail order opt-out program that is designed to support Members in individual instances where mail order requirements create an unanticipated and unique hardship. The opt-out program shall not apply to specialty pharmacy.

4.2.3.3.2 The MCO shall conduct both prospective and retrospective DUR for all Members receiving MAT for Substance Use Disorder to ensure that Members are not receiving opioids and/or benzodiazepines from other health care Providers while receiving MAT.

4.2.3.3.3 The retrospective DUR shall include a review of medical claims to identify Members that are receiving MAT through physician administered drugs (such as methadone, vivitrol, etc.).

4.2.3.4 The MCO shall make available on its website information regarding any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the DHHS-approved modification effective date.

4.2.3.5 Further, the MCO shall notify all Members and Participating Providers impacted by any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the DHHS-approved modification effective date.

4.2.3.6 [Amendment #2:] The MCO shall implement and operate a DUR program that shall be in compliance with Section 1927(g) of the Social Security Act, address Section 1004 provisions of the SUPPORT for Patient and Communities Act, and include:

4.2.3.6.1 Prospective DUR;

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4.2.3.6.2 Retrospective DUR; and

4.2.3.6.3 [Amendment #2:] An educational program for Participating Providers, including prescribers and dispensers; and, [42 CFR 456, subpart K; 42 CFR 438.3(s)(4)]

4.2.3.6.4 [Amendment #2:] DUR program features in accordance with Section 1004 provisions of the SUPPORT for Patient and Communities Act, including:

4.2.3.6.4.1. [Amendment #2:] Safety edit on days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates fills of opioids in excess of limitations identified by the State;

4.2.3.6.4.2. [Amendment #2:] Safety edits on the maximum daily morphine equivalent for treatment of pain and a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;

4.2.3.6.4.3. [Amendment #2:] A claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

4.2.3.6.4.4. [Amendment #2:] A program to monitor and manage the appropriate use of antipsychotic medications by all children including foster children enrolled under the State plan;

4.2.3.6.4.5. [Amendment #2:] Fraud and abuse identification processes that identifies potential fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies; and

4.2.3.6.4.6. [Amendment #2:] Operate like the State's Fee-for-Service DUR program. [42 CFR 456, subpart K; 42 CFR 438.3(s)(4)].

4.2.3.7 The MCO shall submit to DHHS a detailed description of its DUR program prior to the implementation of this Agreement and, if the MCO's DUR program changes, annually thereafter.

4.2.3.7.1 In accordance with Section 1927 (d)(5)(A) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request

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for Prior Authorization one hundred percent (100%) of the time and reimburse for the dispensing of at least a seventy two (72) hour supply of a covered outpatient prescription drug in an emergency situation when Prior Authorization cannot be obtained. [42 CFR 438.210(d)(3)]

4.2.3.8 The MCO shall develop and/or participate in other State of New Hampshire pharmacy-related quality improvement initiatives, as required by DHHS and in alignment with the MCO's QAPI, further described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

4.2.3.8.1 [Amendment #8:] Beginning with calendar year 2022, for the HEDIS Measure "Use of Opioids from Multiple Providers", the MCO shall achieve performance that is less than or equal to the average rate of New England HMO Medicaid health plans as reported by NCQA Quality Compass for the previous calendar year.

4.2.3.9 The MCO shall institute a Pharmacy Lock-In Program for Members, which has been reviewed by DHHS, and complies with requirements included in Section 4.11.6.15 (Limitations on Prior Authorization Requirements). If the MCO determines that a Member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to Members regarding the Pharmacy Lock-In determination. The MCO may, provided the MCO receives prior approval from DHHS, implement Lock-In Programs for other medical services.

4.2.3.10 [Amendment #6:] Members shall not be required to change covered prescription drugs more than once per calendar year, with the following exceptions:

4.2.3.10.1 [Amendment #6:] When a Member is new to Medicaid, or switches from one Medicaid MCO to another Medicaid MCO;

4.2.3.10.2 [Amendment #6:] When a covered prescription drug change is initiated by the Member's provider;

4.2.3.10.3 [Amendment #6:] When a biosimilar becomes available to the market;

4.2.3.10.4 [Amendment #6:] When FDA boxed warnings or new clinical guidelines are recognized by CMS;

4.2.3.10.5 [Amendment #6:] When a covered prescription drug is withdrawn from the market because it has been found to be unsafe or removed for another reason; and

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4.2.3.10.6 [Amendment #6:] When a covered prescription is not available due to a supply shortage.

4.2.4 Systems, Data, and Reporting Requirements

4.2.4.1 Systems Requirements

4.2.4.1.1 The MCO shall adjudicate pharmacy claims for its Members using a POS system where appropriate. System modifications include, but are not limited to:

4.2.4.1.1.1. Systems maintenance,

4.2.4.1.1.2. Software upgrades, and

4.2.4.1.1.3. National Drug Code sets, or migrations to new versions of National Council for Prescription Drug Programs (NCPDP).

4.2.4.1.2 Transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated determination during the POS transaction; in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

4.2.4.2 Data and Reporting Requirements

4.2.4.2.1 To demonstrate its compliance with the DHHS PDL, the MCO shall submit to DHHS information regarding its PDL compliance rate.

4.2.4.2.2 In accordance with changes to rebate collection processes in the Affordable Care Act, DHHS shall be responsible for collecting OBRA 90 CMS rebates, inclusive of supplemental, from drug manufacturers on MCO pharmacy claims.

4.2.4.2.3 [Amendment #2:] The MCO shall provide all necessary pharmacy Encounter Data to the State to support the rebate billing process and the MCO shall submit the Encounter Data file within ~~seven (7)~~ fourteen (14) calendar days of claim payment. The Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement.

4.2.4.2.4 The drug utilization information reported to DHHS shall, at a minimum, include information on:

4.2.4.2.4.1. The total number of units of each dosage form,

4.2.4.2.4.2. Strength, and

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4.2.4.2.4.3. Package size by National Drug Code of each covered outpatient drug dispensed, per DHHS encounter specifications. [42 CFR 438.3(s)(2); Section 1927(b) of the Social Security Act]

4.2.4.2.5 The MCO shall establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization reports provided to DHHS. [42 CFR 438.3(s)(3)]

4.2.4.2.6 The MCO shall implement a mechanism to prevent duplicate discounts in the 340B Drug Pricing Program.

4.2.4.2.7 The MCO shall work cooperatively with the State to ensure that all data needed for the collection of CMS and supplemental rebates by the State's pharmacy benefit administrator is delivered in a comprehensive and timely manner, inclusive of any payments made for Members for medications covered by other payers.

4.2.4.2.8 The MCO shall adhere to federal regulations with respect to providing pharmacy data required for DHHS to complete and submit to CMS the Annual Medicaid DUR Report. [42 CFR 438.3(s)(4),(5)]

4.2.4.2.9 The MCO shall provide DHHS reporting regarding pharmacy utilization, polypharmacy, authorizations and the Pharmacy Lock-In Program, medication management, and safety monitoring of psychotropics in accordance with Exhibit O.

4.2.4.2.10 The MCO shall provide to DHHS detailed information regarding providing PCPs and behavioral health Providers access to their patients' pharmacy data and for providing prescriber information to the State PDMP. This data shall be provided in a manner prescribed by DHHS as permitted by State and federal law.

4.2.5 Medication Management

4.2.5.1 Medication Management for All Members

4.2.5.1.1 [Amendment #5:] The MCO shall at least annually conduct Comprehensive Medication Review (CMR) and counseling by a pharmacist or other health care professional to adult and child Members with polypharmacy in accordance with separate guidance.

4.2.5.1.2 In the event the Member does not respond to the MCO's offer to provide medication review and counseling, the MCO shall continue to attempt to provide such services to the Member at least

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monthly or until the Member actively accepts or denies receipt of Medication Management Services.

4.2.5.1.2.1. [Amendment #5:] The MCO shall provide comprehensive medication review and counseling to any Member upon request.

4.2.5.1.3 Polypharmacy is defined as:

4.2.5.1.3.1. Adult members dispensed five (5) or more maintenance drugs based on Generic Product Identifier (GPI) 10 or an equivalent product identification code over a sixty (60) day period (or the equivalent of five (5) maintenance drugs over a sixty (60) day period, for drugs dispensed for several months at a time); and

4.2.5.1.3.2. Child members dispensed four (4) or more maintenance drugs based on GPI 10 or an equivalent product identification code over a sixty (60) day period (or the equivalent of four (4) maintenance drugs over a sixty (60) day period, for drugs dispensed for several months at a time).

4.2.5.1.4 CMR is defined as a systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber. The counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider and is designed to improve patients' knowledge of their prescriptions, over-the-counter medications, herbal therapies and dietary supplements, identify and address problems or concerns that patients may have, and empower patients to self-manage their medications and their health conditions.

4.2.5.1.5 The MCO shall routinely monitor and address the appropriate use of behavioral health medications in children by encouraging the use of, and reimbursing for consultations with, child psychiatrists.

4.2.5.1.6 The MCO may, for purposes of satisfying Medication Management requirements, permit a Subcontract with retail-dispensing pharmacist(s) or another alternative that is also an appropriately credentialed and licensed professional approved by DHHS as part of a medication therapy management program,

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provided that the MCO ensures that the retail-dispensing pharmacist or approved alternative has access to all Member dispensing information, the MCO retains final oversight and accountability, and the MCO receives DHHS review prior to implementation of the program.

4.2.5.2 Medication Management for Children with Special Health Care Needs

4.2.5.2.1 The MCO shall be responsible for active and comprehensive medication management for Children with Special Health Care Needs. The MCO shall offer to Members, their parents, and/or caregivers, comprehensive medication management services for Children with Special Health Care Needs. If comprehensive medication management services for Children with Special Health care Needs are accepted, the MCO shall develop active and comprehensive medication management protocols for Children with Special Health Care Needs that shall include, but not be limited to, the following:

4.2.5.2.1.1. Performing or obtaining necessary health assessments;

4.2.5.2.1.2. Formulating a medication treatment plan according to therapeutic goals agreed upon by prescriber and the Member, parent and caregiver;

4.2.5.2.1.3. Selecting, initiating, modifying, recommending changes to, or administering medication therapy;

4.2.5.2.1.4. Monitoring, which could include lab assessments and evaluating Member's response to therapy;

4.2.5.2.1.5. Consulting with social service agencies on medication management services;

4.2.5.2.1.6. Initial and on-going CMR to prevent medication-related problems and address drug reconciliation, including adverse drug events, followed by targeted medication reviews;

4.2.5.2.1.7. Documenting and communicating information about care delivered to other appropriate health care Providers;

4.2.5.2.1.8. Member education to enhance understanding and appropriate use of medications; and

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4.2.5.2.1.9. Coordination and integration of medication therapy management services with broader health Care Management services to ensure access to Medically Necessary medications wherever Member is placed, including access to out of network pharmacies.

4.2.5.2.1.10. Review of medication use shall be based on the following:

- 4.2.5.2.1.10.1 Pharmacy claims;
- 4.2.5.2.1.10.2 Provider progress reports;
- 4.2.5.2.1.10.3 Comprehensive Assessments and care plans;
- 4.2.5.2.1.10.4 Contact with the Member's Providers;
- 4.2.5.2.1.10.5 Current diagnoses;
- 4.2.5.2.1.10.6 Current behavioral health functioning;
- 4.2.5.2.1.10.7 Information from the family, Provider, DHHS and residential or other treatment entities or Providers; and
- 4.2.5.2.1.10.8 Information shared, to the extent permissible by State and federal law, with DCYF around monitoring and managing the use of psychotropic medications for children in State custody/guardianship.

4.3 Member Enrollment and Disenrollment

4.3.1 Eligibility

4.3.1.1 DHHS has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether the individual shall be enrolled in the MCM program. The MCO shall comply with eligibility decisions made by DHHS.

4.3.1.2 The MCO and its Subcontractors shall ensure that ninety-nine percent (99%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. The MCO shall develop a plan to ensure the provision of pharmacy benefits in the event the eligibility file is not successfully loaded. The MCO shall make DHHS aware, within one (1) business day, of unsuccessful uploads that go beyond twenty-four (24) hours.

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4.3.1.3 The Accredited Standards Committee (ASC) X12 834 enrollment file shall limit enrollment history to eligibility spans reflective of any assignment of the Member with the MCO.

4.3.1.4 To ensure appropriate Continuity of Care, DHHS shall provide up to six (6) months (as available) of all FFS paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all FFS Medicaid Members assigned to the MCO. For Members transitioning from another MCO, DHHS shall also provide such claims data as well as available encounter information regarding the Member supplied by other MCOs.

4.3.1.5 The MCO shall notify DHHS within five (5) business days when it identifies information in a Member's circumstances that may affect the Member's eligibility, including changes in the Member's residence, such as out-of-state claims, or the death of the Member. [42 CFR 438.608(a)(3)]

4.3.1.6 [Amendment #5:] In accordance with separate guidance, the MCO shall outreach to Members thirty (30) calendar days prior to each Member's Medicaid eligibility expiration date to assist the Member with completion and submission of required paperwork. The MCO shall be required to submit their outbound call protocols for DHHS review during the Readiness Review process.

4.3.1.6.1 [Amendment #5:] In accordance with separate guidance, the MCO shall provide support to unwind the Public Health Emergency as may be requested.

4.3.1.6.1.1. [Amendment #8:] The MCO shall take reasonable steps to support its Members prior to and during the Public Health Emergency continuous enrollment unwind period to maintain coverage for eligible beneficiaries, and promote smooth transitions for Members no longer eligible for Medicaid or other coverage.

4.3.1.6.1.2. [Amendment #8:] The MCO shall not conduct outreach to address the backlog of pending Medicaid eligibility cases to Members in a manner that would constitute a violation of federal law, including, but not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Further, compliance with these laws includes providing reasonable

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accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits. [CMS State Health Official Letter, SHO #22-001: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency, March 3, 2022]

4.3.2 [Amendment #3:] Intentionally Left Blank

[Amendment #3:] MCO Role in Work and Community Engagement Requirements for Granite Advantage Members

4.3.2.1 [Amendment #3:] The MCO shall support the implementation and ongoing operations of the work and community engagement eligibility requirements for certain Granite Advantage Members, including but not limited to the activities described in Section 4.3.3 (General Outreach and Member Education Activities) through 4.3.3.2.3 (Status Tracking and Targeted Outreach) of this Agreement.

4.3.3 [Amendment #3:] Intentionally Left Blank

[Amendment #3:] General Outreach and Member Education Activities

4.3.3.1 [Amendment #3:] The MCO shall provide general outreach and education to Granite Advantage Members regarding work and community engagement requirements set forth in the Granite Advantage waiver program and State administrative rules. MCO responsibilities include the following:

4.3.3.1.1 [Amendment #3:] The MCO shall require that Member Services staff participate in DHHS training on work and community engagement requirements;

4.3.3.1.2 [Amendment #3:] The MCO shall modify all Member Services call center scripts and Member Handbooks to provide information and assistance related to work and community engagement requirements;

4.3.3.1.3 [Amendment #3:] In instances in which a Granite Advantage Member contacts the MCO for any reason, the MCO shall:

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~~4.3.3.1.3.1. [Amendment #3:] Inquire as to the Member's awareness of the community engagement requirement;~~

~~4.3.3.1.3.2. [Amendment #3:] Inquire as to the Member's awareness of frailty and other exemptions;~~

~~4.3.3.1.3.3. [Amendment #3:] Inquire as to the Member's awareness of their exemption status;~~

~~4.3.3.1.3.4. [Amendment #3:] Inquire as to the Member's awareness of qualifying activities and good cause exemptions if the Member's community engagement participation is mandatory;~~

~~4.3.3.1.3.5. [Amendment #3:] Explain how to satisfy the community engagement requirements, including the reporting requirements if the Member's community engagement participation is mandatory;~~

~~4.3.3.1.3.6. [Amendment #3:] Coordinate with DHHS to directly connect the Granite Advantage Member to DHHS after speaking with DHHS to accept the call ("warm transfer"); and~~

~~4.3.3.1.3.7. [Amendment #3:] Report these activities in accordance with Exhibit O;~~

~~4.3.3.1.4 [Amendment #3:] The MCO shall participate in and support additional outreach and education initiatives related to work and community engagement requirements for Granite Advantage Members as defined by DHHS.~~

~~4.3.3.2 [Amendment #3:] Member Support Services~~

~~4.3.3.2.1 [Amendment #3:] The MCO shall provide Granite Advantage Members with support related to work and community engagement requirements, including:~~

~~4.3.3.2.1.1. [Amendment #3:] Assistance with DHHS processes for reporting compliance, obtaining good cause or other exemptions: in the event a Member contacts the MCO seeking to report his/her compliance with work requirements or obtain a good cause or other exemption, the MCO shall help the Member navigate DHHS's process for demonstrating such compliance and/or exemption;~~

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~~4.3.3.2.1.2. [Amendment #3:] Connection to other sources of coverage, when applicable: As indicated in the Special Terms and Conditions of the Granite Advantage waiver approved by CMS, in the event the Member becomes ineligible for Medicaid coverage due to the work requirement, the MCO is required to support the State in the screening of eligibility for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 435.916(f).~~

~~4.3.3.2.1.3. [Amendment #3:] Providing Information on options for Members to satisfy the work and community engagement requirements.~~

4.3.3.2.2 [Amendment #3:] Identification of Exempt or Potentially Exempt Members

~~4.3.3.2.2.1. [Amendment #3:] The MCO shall notify DHHS, through a mechanism specified by DHHS, of any Granite Advantage Members that the MCO identifies as potentially exempt.~~

~~4.3.3.2.2.2. [Amendment #3:] The MCO shall conduct analyses of claims and Encounter Data to identify Granite Advantage Members who may be exempt from work and community engagement requirements as defined by the Granite Advantage waiver program.~~

~~4.3.3.2.2.3. [Amendment #3:] The MCO shall conduct claims analysis for all Granite Advantage Members on an ongoing basis, at the frequency defined by DHHS. The MCO shall review all sources of data that may support its understanding of Granite Advantage Members' status related to work and community engagement requirements, including but not limited to:~~

~~4.3.3.2.2.3.1 [Amendment #3:] Information regarding Members' hospitalization;~~

~~4.3.3.2.2.3.2 [Amendment #3:] Information regarding Members' diagnoses and conditions; and~~

~~4.3.3.2.2.3.3 [Amendment #3:] Information regarding any circumstances that would exempt or potentially exempt a Member from being subject to work and community engagement requirements.~~

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4.3.3.2.2.4. [Amendment #3:] ~~The MCO shall also monitor its Care Management systems and the Admissions, Discharge and Transfers (ADT) feed, and as applicable monitor its Subcontractors' Care Management system(s), for hospitalizations, diagnoses, or indications of circumstances that would exempt or potentially exempt Granite Advantage Members from work and community engagement requirements.~~

4.3.3.2.2.5. [Amendment #3:] ~~For Granite Advantage Members identified as potentially exempt from work and community engagement requirements based on the MCO's claims and Encounter Data analysis, the MCO shall attempt to support the Member in obtaining physician certification of the exemption.~~

4.3.3.2.2.6. [Amendment #3:] ~~The MCO shall transmit to DHHS, through a mechanism to be specified by DHHS, information for Members who are exempt or may be exempt.~~

4.3.3.2.2.7. [Amendment #3:] ~~The MCO shall indicate to DHHS that the Granite Advantage Member is potentially exempt from work and community engagement requirements if, based on the MCO's claims analysis, physician certification, and/or Care Management data, the MCO can determine that the Member is exempt.~~

4.3.3.2.2.8. [Amendment #3:] ~~The MCO shall indicate that the Member is potentially exempt if the MCO has determined that the individual meets the criteria for a diagnosis based exemption, but the MCO has not been able to obtain the required physician certification.~~

4.3.3.2.3 [Amendment #3:] ~~Status Tracking and Targeted Outreach~~

4.3.3.2.3.1. [Amendment #3:] ~~The MCO shall receive from DHHS information generated via electronic file related to Granite Advantage Members' work and community engagement requirement status; for example, this information will indicate that the Granite Advantage Member is either "exempt," "mandatory compliant," or "mandatory non-compliant" with the work and community engagement requirements. The MCO~~

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shall be able to receive and process new information in the format designated by DHHS.

4.3.3.2.4 [Amendment #3:] ~~For Granite Advantage Members identified by DHHS as "mandatory non-compliant," the MCO shall perform targeted outreach activities and provide assistance designed to support the Member in becoming compliant with requirements to avoid coverage suspension or termination, as specified by DHHS.~~

4.3.3.2.5 [Amendment #3:] ~~The MCO's outreach to "mandatory non-compliant" Granite Advantage Members shall include, but is not limited to:~~

4.3.3.2.5.1. [Amendment #3:] ~~Telephonic outreach, including outreach above and beyond the initial Member welcome call;~~

4.3.3.2.5.2. [Amendment #3:] ~~Distribution of DHHS-approved mailings or other educational materials; and/or~~

4.3.3.2.5.3. [Amendment #3:] ~~Transmittal of electronic notification(s), including text messaging.~~

4.3.3.2.6 [Amendment #3:] ~~During periods of Member suspension of eligibility due to non-compliance with community engagement requirements or failure to receive an exemption, the MCO shall continue outreach to the suspended Member to assist the Member in completing requirements during the period before final termination of the Member's eligibility.~~

4.3.4 Enrollment

4.3.4.1 Pursuant to 42 CFR 438.54, Members who do not select an MCO as part of the Medicaid application process shall be auto-assigned to an MCO. All newly eligible Medicaid Members shall be given ninety (90) calendar days to either remain in the assigned MCO or select another MCO, if they choose. Members may not change from one (1) MCO to another outside the ninety (90) day plan selection period unless they meet the "cause" criteria as described in Section 4.3.7 (Disenrollment) of this Agreement.

4.3.4.2 The MCO shall accept all Members who choose to enroll in or who were assigned to the MCO by DHHS. The MCO shall accept for automatic re-enrollment Members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less. [42 CFR 438.56(g)]

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4.3.4.2.1 [Amendment #8:] Beginning July 1, 2022, the MCO shall accept temporarily auto re-enrolled Members into their managed care plan after the individual's loss of Medicaid coverage for a period of 120 days or less. The temporary auto re-enrollment mechanism shall remain effective until 17 months after the end of the month in which the public health emergency for COVID-19 ends as declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. § 247d). [Section 1902(e)(14) of the Act]

4.3.4.3 The MCO shall permit each Member to choose a PCP to the extent possible and appropriate. [42 CFR 438.3(l)] In instances in which the Member does not select a PCP at the time of enrollment, the MCO shall assign a PCP to the Member.

4.3.4.4 When assigning a PCP, the MCO shall include the following methodology, if information is available: Member claims history; family member's Provider assignment and/or claims history; geographic proximity; special medical needs; and language/cultural preference.

4.3.5 Non-Discrimination

4.3.5.1 The MCO shall accept new enrollment from individuals in the order in which they apply, without restriction, unless authorized by CMS. [42 CFR 438.3(d)(1)]

4.3.5.2 The MCO shall not discriminate against eligible persons or Members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions. [42 CFR 438.3(d)(3)]

4.3.5.3 The MCO shall not discriminate in enrollment, disenrollment, and re-enrollment against individuals on the basis of health status or need for health care services. [42 CFR 438.3(q)(4)]

4.3.5.4 The MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and shall not use any policy or practice that has a discriminatory effect. [42 CFR 438.3(d)(4)]

4.3.5.5 In accordance with RSA 354-A and all other relevant State and federal laws, the MCO shall not discriminate on the basis of gender identity.

4.3.6 Auto-Assignment

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4.3.6.1 [Amendment #9:] In its sole discretion, DHHS shall consider Opioid Treatment Program (OTP) resolution before using ~~use~~ the following factors for auto-assignment ~~in an order to be determined by DHHS:~~

4.3.6.1.1 Preference to an MCO with which there is already a family affiliation;

4.3.6.1.2 Previous MCO enrollment, when applicable;

4.3.6.1.3 [Amendment #5:] Provider-Member relationship, to the extent obtainable and pursuant to 42 CFR 438 54(d)(7); and

4.3.6.1.4 [Amendment #5:] Any members earned through the Performance-Based Auto-Assignment Program; and

4.3.6.1.5 [Amendment #5:] Equitable distribution among the MCOs.

4.3.6.2 [Amendment #5:] Beginning in January 2021, DHHS shall reward one or more MCOs with membership auto-assignment in accordance with separate Performance-Based Auto-Assignment Program Guidance. Program features include:

~~{Base Contract:} DHHS may revise its auto-assignment methodology to reward those MCOs that demonstrate superior performance on one (1) or more key dimensions of performance as determined by DHHS. The implementation of a performance factor shall be at DHHS's discretion and would potentially precede the equitable distribution factor.~~

4.3.6.2.1 [Amendment #5:] Award(s) of additional membership to eligible high-performing MCO(s) based on performance.

4.3.6.2.2 [Amendment #8:] [Amendment #6:] [Amendment #5:] Membership awards described in separate guidance may include, but are not limited to the following preferential auto-assignment awards by distribution period for high-performing MCO(s):

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[Amendment #10:] Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)					
Distribution for Period Ending	Health Risk Assessment Completion	Encounter Data Timeliness Completeness and Quality	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Total Possible Members Awarded by Period
9/30/2023	2,000			1,000	3,000
12/31/2023	2,000		1,000		3,000
3/31/2024		1,000	1,000	1,000	3,000
6/30/2024		3,000			3,000
8/31/2024			2,000		2,000

Distribution Period for Quarter Ending	[Amendment #8:] Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)							Total Possible Members Awarded By Quarter
	Health Risk Assessment Completion	Encounter Data Timeliness Completeness and Quality	30 Day Re-admissions to Inpatient Psychiatric Facility	ABD and DD Waiver Members Enrolled in MCO Care Management	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Members Discharged from the ED for a SUD Condition Who are Connected to Treatment	
3/31/2023	1,000	1,000					1,000	3,000
6/30/2023			1,000	2,000				3,000

Distribution Period for Quarter Ending	[Amendment #6:] Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)						Total Possible Members Awarded By Quarter
	Health Risk Assessment Completion	Encounter Data Timeliness, Completeness and Quality	Plan-adjusted Psychiatric Boarding	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Members Discharged from the ED for a SUD Condition Who are Connected to Treatment	
12/31/2021	1,000			2,000			3,000
3/31/2022		1,000		1,000	1,000		3,000

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6/30/2022			3,000				3,000
9/30/2022				1,500	1,500		3,000
12/31/2022				1,000	1,000	1,000	3,000

4.3.6.2.2.1. [Amendment #6:] Intentionally left blank [Amendment #5:] Health Risk Assessment Completions (preferential auto-assignment of 1,000 members);

4.3.6.2.2.2. [Amendment #6:] Intentionally left blank [Amendment #5:] Encounter Data Timeliness, Completeness and Quality (preferential auto-assignment of 1,000 members); and

4.3.6.2.2.3. [Amendment #6:] Intentionally left blank [Amendment #5:] Plan-adjusted Psychiatric Boarding (preferential auto-assignment of 3,000 members).

4.3.6.3 [Amendment #5:] Members who meet factors described in Sections 4.3.6.1.1 through 4.3.6.1.3 shall be excluded from MCO auto-assignment awards under the program. DHHS reserves the right to change the auto-assignment process at its discretion.

4.3.6.3.4 [Amendment #5:] 4.3.6.3 DHHS reserves the right to change the auto-assignment process at its discretion.

4.3.7 Disenrollment

4.3.7.1 Member Disenrollment Request

4.3.7.1.1 A Member may request disenrollment "with cause" to DHHS at any time during the coverage year when:

- 4.3.7.1.1.1. The Member moves out of state;
- 4.3.7.1.1.2. The Member needs related services to be performed at the same time; not all related services are available within the network; and receiving the services separately would subject the Member to unnecessary risk;
- 4.3.7.1.1.3. Other reasons, including but not limited to poor quality of care, lack of access to services covered under the Agreement, violation of rights, or lack of access to Providers experienced in dealing with the Member's health care needs. [42 CFR 438.56(d)(2)]; or
- 4.3.7.1.1.4. The MCO does not cover the service the Member seeks because of moral or religious objections. [42 CFR 438.56(d)(2)(i) - (ii)]

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4.3.7.1.1.5. [Amendment #5:] For Member disenrollment requests "with cause" as described in Sections 4.3.7.1.1.2 through 4.3.7.1.1.4, the Member shall first seek redress through the MCO's grievance system.

4.3.7.1.2 A Member may request disenrollment "without cause" at the following times:

4.3.7.1.2.1. During the ninety (90) calendar days following the date of the Member's initial enrollment into the MCO or the date of the DHHS Member notice of the initial auto-assignment/enrollment, whichever is later;

4.3.7.1.2.2. For Members who have an established relationship with a PCP that is only in the network of a non-assigned MCO, the Member can request disenrollment during the first twelve (12) months of enrollment at any time and enroll in the non-assigned MCO;

4.3.7.1.2.3. Once every twelve (12) months;

4.3.7.1.2.4. During enrollment related to renegotiation and re-procurement;

4.3.7.1.2.5. For sixty (60) calendar days following an automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual enrollment/disenrollment opportunity (this provision applies to re-determinations only and does not apply when a Member is completing a new application for Medicaid eligibility); and

4.3.7.1.2.6. When DHHS imposes a sanction on the MCO. [42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i)-(iii)]

4.3.7.1.3 The MCO shall provide Members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period. The notice shall include an explanation of all of the Member's disenrollment rights as specified in this Agreement. [42 CFR 438.56(f)]

4.3.7.1.4 If a Member is requesting disenrollment, the Member (or his or her authorized representative) shall submit an oral or written request to DHHS. [42 CFR 438.56(d)(1)]

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4.3.7.1.5 The MCO shall furnish all relevant information to DHHS for its determination regarding disenrollment, within three (3) business days after receipt of DHHS's request for information.

4.3.7.1.6 [Amendment #6:] Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the Member files the request.

4.3.7.1.7 If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e); 42 CFR 438.56(d)(3); 42 CFR 438.3(q); 42 CFR 438.56(c)]

4.3.7.2 MCO Disenrollment Request

4.3.7.2.1 The MCO shall submit involuntary disenrollment requests to DHHS with proper documentation for the following reasons:

4.3.7.2.1.1. Member has established out of state residence;

4.3.7.2.1.2. Member death;

4.3.7.2.1.3. Determination that the Member is ineligible for enrollment due to being deemed part of an excluded population;

4.3.7.2.1.4. Fraudulent use of the Member identification card; or

4.3.7.2.1.5. In the event of a Member's threatening or abusive behavior that jeopardizes the health or safety of Members, staff, or Providers. [42 CFR 438.56(b)(1); 42 CFR 438.56(b)(3)]

4.3.7.2.2 The MCO shall not request disenrollment because of:

4.3.7.2.2.1. An adverse change in the Member's health status;

4.3.7.2.2.2. The Member's utilization of medical services;

4.3.7.2.2.3. The Member's diminished mental capacity;

4.3.7.2.2.4. The Member's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in

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the MCO seriously impairs the entity's ability to furnish services to either the particular Member or other Members); or

4.3.7.2.2.5. The Member's misuse of substances, prescribed or illicit, and any legal consequences resulting from substance misuse. [Section 1903(m)(2)(A)(v) of the Social Security Act; 42 CFR 438.56(b)(2)]

4.3.7.2.3 If an MCO is requesting disenrollment of a Member, the MCO shall:

4.3.7.2.3.1. Specify the reasons for the requested disenrollment of the Member; and

4.3.7.2.3.2. Submit a request for involuntary disenrollment to DHHS along with documentation and justification, for review.

4.3.7.2.4 [Amendment #6:] Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the MCO files the request.

4.3.7.2.5 If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e)]

4.3.8 Relationship with Enrollment Services

4.3.8.1 The MCO shall furnish information to DHHS or its designee to ensure that, before enrolling, the recipient receives the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

4.4 Member Services

4.4.1 Member Information

4.4.1.1 [Amendment #3:] The MCO shall perform the Member Services responsibilities contained in this Agreement for all Members, including Granite Advantage Members. ~~in accordance with DHHS guidance and the responsibilities described in Section 4.3.2.1 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members).~~

4.4.1.2 Primary Care Provider Information

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4.4.1.2.1 The MCO shall send a letter to a Member upon initial enrollment, and anytime the Member requests a new PCP, confirming the Member's PCP and providing the PCP's name, address, and telephone number.

4.4.1.3 Member Identification Card

4.4.1.3.1 The MCO shall issue an identification card to all New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment.

4.4.1.3.2 The identification card shall include, but is not limited to, the following information and any additional information shall be approved by DHHS prior to use on the identification card:

4.4.1.3.2.1. The Member's name;

4.4.1.3.2.2. The Member's DOB;

4.4.1.3.2.3. The Member's Medicaid identification number assigned by DHHS at the time of eligibility determination;

4.4.1.3.2.4. The name of the MCO;

4.4.1.3.2.5. The twenty-four (24) hours a day, seven (7) days a week toll-free Member Services telephone/hotline number operated by the MCO; and

4.4.1.3.2.6. How to file an appeal or grievance.

4.4.1.3.3 The MCO shall reissue a Member identification card if:

4.4.1.3.3.1. A Member reports a lost card;

4.4.1.3.3.2. A Member has a name change; or

4.4.1.3.3.3. Any other reason that results in a change to the information disclosed on the identification card.

4.4.1.4 Member Handbook

4.4.1.4.1 The MCO shall publish and provide Member information in the form of a Member Handbook at the time of Member enrollment in the plan and, at a minimum, on an annual basis thereafter. The Member Handbook shall be based upon the model Member Handbook developed by DHHS. [42 CFR 438.10(g)(1), 45 CFR 147.200(a); 42 CFR 438.10(c)(4)(ii)]

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4.4.1.4.2 The MCO shall inform all Members by mail of their right to receive free of charge a written copy of the Member Handbook. The MCO shall provide program content that is coordinated and collaborative with other DHHS initiatives. The MCO shall submit the Member Handbook to DHHS for review at the time it is developed as part of Readiness Review and after any substantive revisions at least thirty (30) calendar days prior to the effective date of such change.

4.4.1.4.3 The Member Handbook shall be in easily understood language, and include, but not be limited to, the following information:

4.4.1.4.3.1. General Information:

4.4.1.4.3.1.1 A table of contents;

4.4.1.4.3.1.2 How to access Auxiliary Aids and services, including additional information in alternative formats or languages [42 CFR 438.10(g)(2)(xiii) - (xvi), 42 CFR 438.10(d)(5)(i) - (iii)];

4.4.1.4.3.1.3 [Amendment #6:] DHHS developed definitions, including but not limited to: appeal, Copayment, DME, Emergency Medical Condition, emergency medical transportation, emergency room care, Emergency Services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, ~~hospital, outpatient care~~, Medically Necessary, network, Non-Participating Provider, Participating Provider, PCP, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, Provider, rehabilitation services and devices, skilled nursing care, specialist; and urgent care [42 CFR 438.10(c)(4)(i)];

4.4.1.4.3.1.4 The necessity definitions used in determining whether services will be covered;

4.4.1.4.3.1.5 A reminder to report to DHHS any change of address, as Members shall be liable for premium payments paid during period of ineligibility;

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4.4.1.4.3.1.6 Information and guidance as to how the Member can effectively use the managed care program [42 CFR 438.10(g)(2)];

4.4.1.4.3.1.7 Appointment procedures;

4.4.1.4.3.1.8 How to contact Service Link Aging and Disability Resource Center and the DHHS Medicaid Service Center that can provide all Members and potential Members choice counseling and information on managed care;

4.4.1.4.3.1.9 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including the MCO's toll-free telephone line and website, the toll-free telephone number for Member Services, the toll-free telephone number for Medical Management, and the toll-free telephone number for any other unit providing services directly to Members [42 CFR 438.10(g)(2)(xiii) - (xvi)];

4.4.1.4.3.1.10 How to access the NH DHHS Office of the Ombudsman and the NH Office of the Long Term Care Ombudsman;

4.4.1.4.3.1.11 The policies and procedures for disenrollment;

4.4.1.4.3.1.12 A description of the transition of care policies for potential Members and Members [42 CFR 438.62(b)(3)];

4.4.1.4.3.1.13 Cost-sharing requirements [42 CFR 438.10(g)(2)(viii)];

4.4.1.4.3.1.14 A description of utilization review policies and procedures used by the MCO;

4.4.1.4.3.1.15 A statement that additional information, including information on the structure and operation of the MCO plan and Physician Incentive Plans, shall be made available upon request [42 CFR 438.10(f)(3), 42 CFR 438.3(i)];

4.4.1.4.3.1.16 Information on how to report suspected fraud or abuse [42 CFR 438.10(g)(2)(xii) - (xvi)];

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- 4.4.1.4.3.1.17 Information about the role of the PCP and information about choosing and changing a PCP [42 CFR 438.10(g)(2)(x)];
- 4.4.1.4.3.1.18 Non-Participating Providers and cost-sharing on any benefits carved out and provided by DHHS [42 CFR 438.10(g)(2)(i) - (ii)];
- 4.4.1.4.3.1.19 How to exercise Advance Directives [42 CFR 438.10(g)(2)(xii), 42 CFR 438.3(j)];
- 4.4.1.4.3.1.20 Advance Directive policies which include a description of current State law. [42 CFR 438.3(j)(3)];
- 4.4.1.4.3.1.21 Information on the parity compliance process, including the appropriate contact information, as required by Section 4.11.4. (Parity);
- 4.4.1.4.3.1.22 [Amendment #3:] Intentionally left blank. Any information pertaining to Granite Advantage Members as required by Section 4.3.2.1 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members); and
- 4.4.1.4.3.1.23 Any restrictions on the Member's freedom of choice among Participating Providers [42 CFR 438.10(g)(2)(vi) - (vii)].
- 4.4.1.4.3.2. Benefits:
- 4.4.1.4.3.2.1 How and where to access any benefits provided, including Maternity services, Family Planning Services and NEMT services [42 CFR 438.10(g)(2)(i)-(ii), (vi - vii)].
- 4.4.1.4.3.2.2 Detailed information regarding the amount, duration, and scope of all available benefits so that Members understand the benefits to which they are entitled [42 CFR 438.10(g)(2)(iii) - (iv)];
- 4.4.1.4.3.2.3 How to access EPSDT services and component services if Members under age twenty-one (21) entitled to the EPSDT benefit are enrolled in the MCO;

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4.4.1.4.3.2.4 How and where to access EPSDT benefits delivered outside the MCO, if any [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.2.5 How transportation is provided for any benefits carved out of this Agreement and provided by DHHS [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.2.6 Information explaining that, in the case of a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO shall inform Members that the service is not covered and how Members can obtain information from DHHS about how to access those services [42 CFR 438.10(g)(2)(ii)(A) - (B), 42 CFR 438.102(b)(2)];

4.4.1.4.3.2.7 A description of pharmacy policies and pharmacy programs; and

4.4.1.4.3.2.8 How emergency care is provided, including:

4.4.1.4.3.2.8.1.1 The extent to which, and how, after hours and emergency coverage are provided; .

4.4.1.4.3.2.8.1.2 What constitutes an Emergency Service and an Emergency Medical Condition;

4.4.1.4.3.2.8.1.3 The fact that Prior Authorization is not required for Emergency Services; and

4.4.1.4.3.2.8.1.4 The Member's right to use a hospital or any other setting for emergency care [42 CFR 438.10(g)(2)(v)].

4.4.1.4.3.3. Service Limitations:

4.4.1.4.3.3.1 An explanation of any service limitations or exclusions from coverage;

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4.4.1.4.3.3.2 An explanation that the MCO cannot require a Member to receive prior approval prior to choosing a family planning Provider [42 CFR 438.10(g)(2)(vii)];

4.4.1.4.3.3.3 A description of all pre-certification, Prior Authorization criteria, or other requirements for treatments and services;

4.4.1.4.3.3.4 Information regarding Prior Authorization in the event the Member chooses to transfer to another MCO and the Member's right to continue to utilize a Provider specified in a Prior Authorization for a period of time regardless of whether the Provider is participating in the MCO network;

4.4.1.4.3.3.5 The policy on referrals for specialty care and for other Covered Services not furnished by the Member's PCP [42 CFR 438.10(g)(2)(iii) - (iv)];

4.4.1.4.3.3.6 Information on how to obtain services when the Member is out-of-state and for after-hours coverage [42 CFR 438.10(g)(2)(v)]; and

4.4.1.4.3.3.7 A notice stating that the MCO shall be liable only for those services authorized by or required of the MCO.

4.4.1.4.3.4. Rights and Responsibilities:

4.4.1.4.3.4.1 Member rights and protections, outlined in Section 4.4.3 (Member Rights), including the Member's right to obtain available and accessible health care services covered under the MCO. [42 CFR 438.100(b)(2)(i) - (vi), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(b)(3)].

4.4.1.4.3.5. Grievances, Appeals, and Fair Hearings Procedures and Timeframes:

4.4.1.4.3.5.1 The right to file grievances and appeals;

4.4.1.4.3.5.2 The requirements and timeframes for filing grievances or appeals;

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4.4.1.4.3.5.3 The availability of assistance in the filing process for grievances and appeals;

4.4.1.4.3.5.4 The right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and

4.4.1.4.3.5.5 The right to have benefits continue pending the appeal or request for State fair hearing if the decision involves the reduction or termination of benefits, however, if the Member receives an adverse decision then the Member may be required to pay for the cost of service(s) furnished while the appeal or State fair hearing is pending. [42 CFR 438.10(g)(2)(xi)(A)-(E)]

4.4.1.4.4 Member Handbook Dissemination

4.4.1.4.4.1. The MCO shall mail the Member Handbook to new Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment. [42 CFR 438.10(g)(3)(i) - (iv)]

4.4.1.4.4.2. The MCO shall advise the Member in paper or electronic form that the Member Handbook information is available on the internet, and include the applicable internet address, provided that Members with disabilities who cannot access this information online are provided Auxiliary Aids and services upon request at no cost. [42 CFR 438.10(d)(3)] Alternatively, the MCO may provide the information by any other method that can reasonably be expected to result in the Member receiving that information. The MCO shall provide the Member Handbook information by email after obtaining the Member's agreement to receive the information electronically. [42 CFR 438.10(g)(3)(i) - (iv)]

4.4.1.4.4.3. The MCO shall notify all Members, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the MCO's website. [42 CFR 438.10(g)(3)(i) - (iv)] The Member information appearing on the website (also available in paper form) shall include the following, at a minimum:

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4.4.1.4.4.3.1 Information contained in the Member Handbook;

4.4.1.4.4.3.2 Information on how to file grievances and appeals;

4.4.1.4.4.3.3 Information on the MCO's Provider network for all Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers):

- (1) Names and any group affiliations;
- (2) Street addresses;
- (3) Office hours;
- (4) Telephone numbers;
- (5) [Amendment #7:] Website (whenever web presence exists) (if applicable);
- (6) Specialty (if any),
- (7) Description of accommodations offered for people with disabilities;
- (8) [Amendment #10:] The cultural and linguistic capabilities of Participating Providers, including languages (including American Sign Language (ASL)) offered by the Provider or a skilled medical interpreter at the Provider's office, ~~and whether the Provider has completed cultural competence training~~;
- (9) Gender of the Provider;
- (10) Identification of Providers that are not accepting new Members; and
- (11) Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(g)(2)(vi) - (vii)] .

4.4.1.4.4.4. The MCO shall produce a revised Member Handbook, or an insert, informing Members of changes to Covered Services, upon DHHS notification of any change in Covered Services, and at least thirty

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(30) calendar days prior to the effective date of such change. This includes notification of any policy to discontinue coverage of a counseling or referral service based on moral or religious objections and how the Member can access those services. [42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4)]

4.4.1.4.4.5. [Amendment #9:] The MCO shall use Member notices, as applicable, in accordance with the model notices developed by DHHS. [42 CFR 438.10(c)(4)(ii)] For any change that affects Member rights, filing requirements, time frames for grievances, appeals, and State fair hearings, availability of assistance in submitting grievances and appeals, and toll-free numbers of the MCO grievance system resources, the MCO shall give each Member written notice of the change at least thirty (30) calendar days before the intended effective date of the change. ~~The MCO shall also notify all Members of their disenrollment rights, at a minimum, annually.~~ The MCO shall utilize notices that describe transition of care policies for Members and potential Members. [42 CFR 438.62(b)(3)]

4.4.1.5 Provider Directory

4.4.1.5.1 The MCO shall publish a Provider Directory that shall be reviewed by DHHS prior to initial publication and distribution. The MCO shall submit the draft Provider Directory and all substantive changes to DHHS for review.

4.4.1.5.2 The following information shall be in the MCO's Provider Directory for all Participating Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers):

- 4.4.1.5.2.1. Names and any group affiliations;
- 4.4.1.5.2.2. Street addresses;
- 4.4.1.5.2.3. Office hours;
- 4.4.1.5.2.4. Telephone numbers;
- 4.4.1.5.2.5. [Amendment #7:] Website (whenever web presence exists) (if applicable);
- 4.4.1.5.2.6. Specialty (if any),

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- 4.4.1.5.2.7. Gender;
- 4.4.1.5.2.8. Description of accommodations offered for people with disabilities;
- 4.4.1.5.2.9. [Amendment #8:] The cultural and linguistic capabilities of Participating Providers, including languages (including ASL) offered by the Participating Provider or a skilled medical interpreter at the Provider's office, ~~and whether the Participating Provider has completed cultural competence training;~~
- 4.4.1.5.2.10. Hospital affiliations (if applicable);
- 4.4.1.5.2.11. Board certification (if applicable);
- 4.4.1.5.2.12. Identification of Participating Providers that are not accepting new patients; and
- 4.4.1.5.2.13. Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(h)(1)(i) - (viii); 42 CFR 438.10(h)(2)]

4.4.1.5.3 The MCO shall send a letter to New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment directing the Member to the Provider Directory on the MCO's website and informing the Member of the right to a printed version of the Provider Directory upon request.

4.4.1.5.4 The MCO shall disseminate Practice Guidelines to Members and potential Members upon request as described in Section 4.8.2 (Practice Guidelines and Standards). [42 CFR 438.236(c)]

4.4.1.5.5 The MCO shall notify all Members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the MCO's website in a machine readable file and format as specified by CMS.

4.4.1.5.6 [Amendment #8:] The MCO shall update the paper copy of the Provider Directory at least monthly if the MCO does not have a mobile-enabled electronic directory, or quarterly, if the MCO has a mobile-enabled, electronic provider directory; and shall update an electronic directory no later than thirty (30) calendar days after the MCO receives updated *provider* information. [42 CFR 438.10(h)(3-4)].

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4.4.1.5.7 The MCO shall post on its website a searchable list of all Participating Providers. At a minimum, this list shall be searchable by Provider name, specialty, location, and whether the Provider is accepting new Members.

4.4.1.5.8 The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes. The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory.

4.4.1.5.9 Thirty (30) calendar days after the effective date of this Agreement or ninety (90) calendar days prior to the Program Start Date, whichever is later, the MCO shall develop and submit the draft website Provider Directory template to DHHS for review; thirty (30) calendar days prior to Program Start Date the MCO shall submit the final website Provider Directory.

4.4.1.5.10 Upon the termination of a Participating Provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify Members who received their primary care from, or was seen on a regular basis by, the terminated Provider. [42 CFR 438.10(f)(1)]

4.4.2 Language and Format of Member Information

4.4.2.1 The MCO shall have in place mechanisms to help potential Members and Members understand the requirements and benefits of the MCO. [42 CFR 438.10(c)(7)]

4.4.2.2 The MCO shall use the DHHS developed definitions consistently in any form of Member communication. The MCO shall develop Member materials utilizing readability principles appropriate for the population served.

4.4.2.3 The MCO shall provide all enrollment notices, information materials, and instructional materials relating to Members and potential Members in a manner and format that may be easily understood and readily accessible in a font size no smaller than twelve (12) point. [42 CFR 438.10(c)(1), 42 CFR 438.10(d)(6)(ii) - (iv)]

4.4.2.4 The MCO's written materials shall be developed in compliance with all applicable communication access requirements at the request of the Member or prospective Member at no cost.

4.4.2.5 Information shall be communicated in an easily understood language and format, including alternative formats and in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities or LEP.

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4.4.2.6 The MCO shall inform Members that information is available in alternative formats and how to access those formats. [42 CFR 438.10(d)(3), 42 CFR 438.10(d)(6)(i) - (iv)]

4.4.2.7 The MCO shall make all written Member information available in English, Spanish, and any other state-defined prevalent non-English languages of MCM Members. [42 CFR 438.10(d)(1)]

4.4.2.8 [Amendment #5:] All written Member information critical to obtaining services for potential enrollees shall include at the bottom, taglines printed in a conspicuously visible font size in large print, and in the non-English languages prevalent among MCM Members, to explaining the availability of written translation or oral interpretation, to understand the information provided and include the toll-free and teletypewriter (TTY)/TDD telephone number of the MCO's Member Services Center. [42 CFR 438.10(d)(3)]

4.4.2.9 [Amendment #5:] The large print tagline must be printed in a conspicuously visible font size, and shall include information on how to request Auxiliary Aids and services, including materials in alternative formats. Upon request, the MCO shall provide all written Member and potential enrollee critical to obtaining services information in large print with a font size no smaller than eighteen (18) point. [42 CFR 438.10(d)(2-3), 42 CFR 438.10(d)(6)(ii) - (iv)]

4.4.2.10 Written Member information shall include at a minimum:

4.4.2.10.1 Provider Directories;

4.4.2.10.2 Member Handbooks;

4.4.2.10.3 Appeal and grievance notices; and

4.4.2.10.4 Denial and termination notices.

4.4.2.11 The MCO shall also make oral interpretation services available free of charge to Members and potential Members for MCO Covered Services. This applies to all non-English languages, not just those that DHHS identifies as languages of other major population groups. Members shall not to be charged for interpretation services. [42 CFR 438.10(d)(4)]

4.4.2.12 The MCO shall notify Members that oral interpretation is available for any language and written information is available in languages prevalent among MCM Members; the MCO shall notify Members of how to access those services. [42 CFR 438.10(d)(4), 42 CFR 438.10(d)(5)(i) - (iii)]

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4.4.2.13 The MCO shall provide Auxiliary Aids such as TTY/TDD and ASL interpreters free of charge to Members or potential Members who require these services. [42 CFR 438.10(d)(4)] The MCO shall take into consideration the special needs of Members or potential Members with disabilities or LEP. [42 CFR 438.10(d)(5)(i) - (iii)]

4.4.3 Member Rights

4.4.3.1 The MCO shall have written policies which shall be included in the Member Handbook and posted on the MCO website regarding Member rights, such that each Member is guaranteed the right to:

4.4.3.1.1 Receive information on the MCM program and the MCO to which the Member is enrolled;

4.4.3.1.2 Be treated with respect and with due consideration for his or her dignity and privacy and the confidentiality of his or her PHI and PI as safeguarded by State rules and State and federal laws;

4.4.3.1.3 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

4.4.3.1.4 Participate in decisions regarding his/her health care, including the right to refuse treatment;

4.4.3.1.5 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

4.4.3.1.6 Request and receive a copy of his/her medical records free of charge, and to request that they be amended or corrected;

4.4.3.1.7 Request and receive any MCO's written Physician Incentive Plans;

4.4.3.1.8 Obtain benefits, including Family Planning Services and supplies, from Non-Participating Providers;

4.4.3.1.9 Request and receive a Second Opinion; and

4.4.3.1.10 Exercise these rights without the MCO or its Participating Providers treating the Member adversely. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(i)-(vi)]; 42 CFR 438.100(c); 42 CFR 438.10(f)(3); 42 CFR 438.10(g)(2)(vi) - (vii); 42 CFR 438.10(g)(2)(ix); 42 CFR 438.3(i)]

4.4.4 Member Communication Supports

4.4.4.1 The MCO shall embrace and further the concept of "every door for Members is the right door" to eliminate barriers and create a

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more flexible and responsive approach to person-centered service delivery. The MCO shall provide twenty-four (24) hours a day, seven (7) days a week supports such as PCP, behavioral health and specialist referrals, health coaching, assistance with social determinants of health, access to a nurse advice line, and a Member portal.

4.4.4.2 During the Readiness Review period, the MCO shall provide a blueprint of its Member portal for review by DHHS.

4.4.4.3 Member Call Center

4.4.4.3.1 [Amendment #5:] The MCO shall operate a toll-free NH specific call center Monday through Friday. The MCO shall submit the holiday calendar to DHHS for review and approval ninety (90) calendar days prior to the end of each calendar year.

4.4.4.3.2 The MCO shall ensure that the Member Call Center integrates support for physical and Behavioral Health Services including meeting the requirement that the MCO have a call line that is in compliance with requirements set forth in Section 4.11.1.19 (Member Service Line), works efficiently to resolve issues, and is adequately staffed with qualified personnel who are trained to accurately respond to Members. At a minimum, the Member Call Center shall be operational:

4.4.4.3.2.1. Two (2) days per week: eight (8:00) am Eastern Standard Time (EST) to five (5:00) pm EST;

4.4.4.3.2.2. Three (3) days per week: eight (8:00) am EST to eight (8:00) pm EST; and

4.4.4.3.2.3. During major program transitions, additional hours and capacity shall be accommodated by the MCO.

4.4.4.3.3 The Member Call Center shall meet the following minimum standards, which DHHS reserves the right to modify at any time:

4.4.4.3.3.1. Call Abandonment Rate: Fewer than five percent (5%) of calls shall be abandoned;

4.4.4.3.3.2. [Amendment #5:] Average Speed of Answer: Eighty-five percent (85%) ~~Ninety percent (90%)~~ of calls shall be answered with live voice within thirty (30) seconds; and

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4.4.4.3.3.3. Voicemail or answering service messages shall be responded to no later than the next business day.

4.4.4.3.4 [Amendment #5:] The MCO shall coordinate its Member Call Center with the DHHS Customer Service Center, the Member Service Line and all community-based and statewide crisis lines to include, at a minimum, the development of a warm transfer protocol for Members.

4.4.4.4 Welcome Call

4.4.4.4.1 The MCO shall make a welcome call to each New Member within thirty (30) calendar days of the Member's enrollment in the MCO.

4.4.4.4.2 The welcome call shall, at a minimum:

4.4.4.4.2.1 Assist the Member in selecting a PCP or confirm selection of a PCP;

4.4.4.4.2.2 Arrange for a wellness visit with the Member's PCP (either previously identified or selected by the Member from a list of available PCPs), which shall include:

4.4.4.4.2.2.1 Assessments of both physical and behavioral health,

4.4.4.4.2.2.2 Screening for depression, mood, suicidality, and Substance Use Disorder, and

4.4.4.4.2.2.3 Development of a health, wellness and care plan;

4.4.4.4.2.3 Include a Health Risk Assessment Screening as required in Section 4.10.2.2, or schedule the Health Risk Assessment to be conducted within the time limits identified in this Agreement;

4.4.4.4.2.4 Screen for special needs, physical and behavioral health, and services of the Member;

4.4.4.4.2.5 Answer any other Member questions about the MCO;

4.4.4.4.2.6 Ensure Members can access information in their preferred language; and

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4.4.4.4.2.7. Remind Members to report to DHHS any change of address, as Members shall be liable for premium payments paid during period of ineligibility.

4.4.4.4.3 Regardless of the completion of the welcome call, the MCO shall complete Health Risk Assessment Screenings as required in 4.10.2.2

4.4.4.5 Member Hotline

4.4.4.5.1 The MCO shall establish a toll-free Member Service automated hotline that operates outside of the Member Call Center standard hours, Monday through Friday, and at all hours on weekends and holidays.

4.4.4.5.2 The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for Members to leave messages.

4.4.4.5.3 The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages. Return voicemail calls shall be made no later than the next business day.

4.4.4.5.4 The MCO may substitute a live answering service in place of an automated system.

4.4.4.6 Program Website

4.4.4.6.1 The MCO shall develop and maintain, consistent with DHHS standards and other applicable State and federal laws, a website to provide general information about the MCO's program, its Participating Provider network, its formulary, Prior Authorization requirements, the Member Handbook, its services for Members, and its Grievance and Appeal Processes.

4.4.4.6.2 The MCO shall ensure that any PHI, PI or other Confidential Information solicited shall not be maintained, stored or captured on the website and shall not be further disclosed except as provided by this Agreement.

4.4.4.6.3 The solicitation or disclosure of any PHI, PI or other Confidential Information shall be subject to the requirements in Exhibit I, Exhibit K Exhibit N (Liquidated Damages Matrix) and all applicable State and federal laws, rules, and regulations.

4.4.4.6.4 Unless approved by DHHS and clear notice is provided to users of the website, the MCO shall not track, disclose or use site visitation for its website analytics or marketing.

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4.4.4.6.5 If the MCO chooses to provide required information electronically to Members, it shall:

4.4.4.6.5.1. Be in a format and location that is prominent and readily accessible;

4.4.4.6.5.2. Be provided in an electronic form which can be electronically retained and printed;

4.4.4.6.5.3. Be consistent with content and language requirements;

4.4.4.6.5.4. Notify the Member that the information is available in paper form without charge upon request; and

4.4.4.6.5.5. Provide, upon request, information in paper form within five (5) business days. [42 CFR 438.10(c)(6)(i) - (v)]

4.4.4.6.6 The MCO program content included on the website shall be:

4.4.4.6.6.1. Written in English, Spanish, and any other of the commonly encountered languages of Members;

4.4.4.6.6.2. Culturally appropriate;

4.4.4.6.6.3. Appropriate to the reading literacy of the population served; and

4.4.4.6.6.4. Geared to the health needs of the enrolled MCO program population.

4.4.4.6.7 The MCO's website shall be compliant with the federal DOJ "Accessibility of State and Local Government Websites to People with Disabilities."

4.4.5 Marketing

4.4.5.1 The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other Cold Call Marketing to potential Members. The MCO shall submit all MCO Marketing material to DHHS for approval before distribution.

4.4.5.2 DHHS shall identify any required changes to the Marketing Materials within thirty (30) calendar days. If DHHS has not responded to a request for review by the thirtieth calendar day, the MCO may proceed to use the submitted materials. [42 CFR 438.104(b)(1)(i) - (ii), 42 CFR 438.104(b)(1)(iv) - (v)]

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4.4.5.3 The MCO shall comply with federal requirements for provision of information that ensures the potential Member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

4.4.5.4 The MCO Marketing Materials shall not contain false or materially misleading information. The MCO shall not offer other insurance products as inducement to enroll.

4.4.5.5 The MCO shall ensure that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or DHHS. The MCO's Marketing Materials shall not contain any written or oral assertions or statements that:

4.4.5.5.1 The recipient shall enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

4.4.5.5.2 The MCO is endorsed by CMS, the State or federal government, or a similar entity. [42 CFR 438.104(b)(2)(i) - (ii)]

4.4.5.6 The MCO shall distribute Marketing Materials to the entire State. The MCO's Marketing Materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. The MCO shall not release and make public statements or press releases concerning the program without the prior consent of DHHS. [42 CFR 438.104(b)(1)(i) - (ii), 42 CFR 438.104(b)(1)(iv) - (v)]

4.4.6 Member Engagement Strategy

4.4.6.1 The MCO shall develop and facilitate an active Member Advisory Board that is composed of Members who represent its Member population.

4.4.6.2 Member Advisory Board

4.4.6.2.1 Representation on the Member Advisory Board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the MCM program.

4.4.6.2.2 The Member Advisory Board shall meet at least four (4) times per year.

4.4.6.2.3 The Member Advisory Board shall meet in-person or through interactive technology, including but not limited to a conference call or webinar and provide Member perspective(s) to influence the MCO's QAPI program changes (as further described in Section 4.12.3 (Quality Assessment and Performance Improvement Program)).

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4.4.6.2.4 All costs related to the Member Advisory Board shall be the responsibility of the MCO.

4.4.6.3 In-Person Regional Member Meetings

4.4.6.3.1 The MCO shall hold in-person regional Member meetings for two-way communication where Members can provide input and ask questions, and the MCO can ask questions and obtain feedback from Members.

4.4.6.3.2 Regional meetings shall be held at least twice each Agreement year in demographically different locations in NH. The MCO shall make efforts to provide video conferencing opportunities for Members to attend the regional meetings. If video conferencing is unavailable, the MCO shall use alternate technologies as available for all meetings.

4.4.6.3.3 [Amendment #6:] Intentionally left blank ~~The MCO shall report on the activities of these meetings including a summary of meeting dates, attendees, topics discussed and actions taken in response to Member contributions to DHHS in the MCM Comprehensive Annual Report, in accordance with Exhibit O.~~

4.4.6.3.4 [Amendment #5:] For the period January 1, 2021 through June 30, 2021, the MCO may utilize remote technologies for regional Member meetings.

4.4.6.3.4.1. [Amendment #6:] Beginning July 1, 2021, the MCO shall accommodate in-person and remote technologies for regional Member meetings.

4.4.7 Cultural and Accessibility Considerations

4.4.7.1 The MCO shall participate in DHHS's efforts to promote the delivery of services in a culturally and linguistically competent manner to all Members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [42 CFR 438.206(c)(2)]

4.4.7.2 The MCO shall ensure that Participating Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or behavioral disabilities. [42 CFR 438.206(c)(3)]

4.4.7.3 Cultural Competency Plan

4.4.7.3.1 In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how it will ensure that services are provided in a culturally and

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linguistically competent manner to all Members, including those with LEP, using qualified staff, interpreters, and translators in accordance with Exhibit O.

4.4.7.3.2 The Cultural Competency Plan shall describe how the Participating Providers, and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the each Member and protects and preserves a Member's dignity.

4.4.7.3.3 The MCO shall work with the DHHS Office of Health Equity to address cultural and linguistic considerations.

4.4.7.4 Communication Access

4.4.7.4.1 The MCO shall develop effective methods of communicating and working with its Members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as Members who have low-vision or hearing loss, and accommodating Members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

4.4.7.4.2 The MCO shall develop effective and appropriate methods for identifying, flagging in electronic systems, and tracking Members' needs for communication assistance for health encounters including preferred spoken language for all encounters, need for interpreter, and preferred language for written information.

4.4.7.4.3 The MCO shall adhere to certain quality standards in delivering language assistance services, including using only Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators as defined in Section 2.1.104 through Section 2.1.107 (Definitions).

4.4.7.4.4 The MCO shall ensure the competence of employees providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. The MCO shall not:

4.4.7.4.4.1. Require a Member with LEP to provide his or her own interpreter;

4.4.7.4.4.2. Rely on an adult accompanying a Member with LEP to interpret or facilitate communication, except:

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4.4.7.4.4.2.1 In an emergency involving an imminent threat to the safety or welfare of the Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available, or

4.4.7.4.4.2.2 Where the Member with LEP specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;

4.4.7.4.4.3. Rely on a minor to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of a Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available; or

4.4.7.4.4.4. Rely on staff other than Qualified Bilingual/Multilingual Staff to communicate directly with Members with LEP. [45 CFR 92.201(e)]

4.4.7.4.5 The MCO shall ensure interpreter services are available to any Member who requests them, regardless of the prevalence of the Member's language within the overall program for all health plan and MCO services, exclusive of inpatient services.

4.4.7.4.6 The MCO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e. will provide meaningful access) for all Members in all situations. The most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and shall be based upon the unique needs and circumstances of each Member.

4.4.7.4.7 Accordingly, the MCO shall provide the most appropriate interpretation service possible under the circumstances. In all cases, the MCO shall provide in-person interpreter services when deemed clinically necessary by the Provider of the encounter service.

4.4.7.4.8 The MCO shall not use low-quality video remote interpreting services. In instances where the Qualified Interpreters are being provided through video remote interpreting services, the MCO's health programs and activities shall provide:

4.4.7.4.8.1. Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-

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quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;

4.4.7.4.8.2. A sharply delineated image that is large enough to display the interpreter's face and the participating Member's face regardless of the Member's body position;

4.4.7.4.8.3. A clear, audible transmission of voices; and

4.4.7.4.8.4. Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. [45 CFR 92.201(f)]

4.4.7.4.9 The MCO shall bear the cost of interpretive services and communication access, including ASL interpreters and translation into Braille materials as needed for Members with hearing loss and who are low-vision or visually impaired.

4.4.7.4.10 The MCO shall communicate in ways that can be understood by Members who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the Member's health and health care.

4.4.7.4.11 If the Member declines free interpretation services offered by the MCO, the MCO shall have a process in place for informing the Member of the potential consequences of declination with the assistance of a competent interpreter to assure the Member's understanding, as well as a process to document the Member's declination.

4.4.7.4.12 Interpreter services shall be offered by the MCO at every new contact. Every declination requires new documentation by the MCO of the offer and decline.

4.4.7.4.13 The MCO shall comply with applicable provisions of federal laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which prohibits the MCO from discriminating on the basis of race, color, or national origin.

4.4.7.4.14 As clarified by Executive Order 13166, Improving Access to Services for Persons with LEP, and resulting agency

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guidance, national origin discrimination includes discrimination on the basis of LEP. To ensure compliance with Title VI of the Civil Rights Act of 1964, the MCO shall take reasonable steps to ensure that LEP Members have meaningful access to the MCO's programs.

4.4.7.4.15 Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. The MCO is encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. Additionally, the MCO is encouraged to develop and implement a written language access plan to ensure it is prepared to take reasonable steps to provide meaningful access to each Member with LEP who may require assistance.

4.5 Member Grievances and Appeals

4.5.1 General Requirements

4.5.1.1 The MCO shall develop, implement and maintain a Grievance System under which Members may challenge the denial of coverage of, or payment for, medical assistance and which includes a Grievance Process, an Appeal Process, and access to the State's fair hearing system. [42 CFR 438.402(a); 42 CFR 438.228(a)] The MCO shall ensure that the Grievance System is in compliance with this Agreement, 42 CFR 438 Subpart F, State law, as applicable, and NH Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

4.5.1.2 The MCO shall provide to DHHS a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for DHHS's review and approval during the Readiness Review period. Any proposed changes to the Grievance System shall be reviewed by DHHS thirty (30) calendar days prior to implementation.

4.5.1.3 The Grievance System shall be responsive to any grievance or appeal of Dual-Eligible Members. To the extent such grievance or appeal is related to a Medicaid service, the MCO shall handle the grievance or appeal in accordance with this Agreement.

4.5.1.4 In the event the MCO, after review, determines that the Dual-Eligible Member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the Member to the State's Health Insurance Assistance Program (SHIP), which is currently administered by Service Link Aging and Disability Resource Center.

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4.5.1.5 The MCO shall be responsible for ensuring that the Grievance System (Grievance Process, Appeal Process, and access to the State's fair hearing system) complies with the following general requirements. The MCO shall:

4.5.1.5.1 Provide Members with all reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the Member in providing written consent for appeals [42 CFR 438.406(a); 42 CFR 438.228(a)];

4.5.1.5.2 Acknowledge receipt of each grievance and appeal (including oral appeals), unless the Member or authorized Provider requests expedited resolution [42 CFR 438.406(b)(1); 42 CFR 438.228(a)];

4.5.1.5.3 Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making [42 CFR 438.406(b)(2)(i); 42 CFR 438.228(a)];

4.5.1.5.4 Ensure that decision makers take into account all comments, documents, records, and other information submitted by the Member or his or her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination [42 CFR 438.406(b)(2)(iii); 42 CFR 438.228(a)];

4.5.1.5.5 Ensure that, if deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the Member's condition or disease:

4.5.1.5.5.1. An appeal of a denial based on lack of medical necessity;

4.5.1.5.5.2. A grievance regarding denial of expedited resolutions of an appeal; or

4.5.1.5.5.3. A grievance or appeal that involves clinical issues. [42 CFR 438.406(b)(2)(ii)(A) - (C); 42 CFR 438.228(a)].

4.5.1.5.6 Ensure that Members are permitted to file appeals and State fair hearings after receiving notice that an adverse action is upheld [42 CFR 438.402(c)(1); 42 CFR 438.408].

4.5.1.6 The MCO shall send written notice to Members and Participating Providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

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4.5.1.7 The MCO shall provide information as specified in 42 CFR 438.10(g) about the Grievance System to Providers and Subcontractors at the time they enter into a contract or Subcontract. The information shall include, but is not limited to:

4.5.1.7.1 The Member's right to file grievances and appeals and requirements and timeframes for filing;

4.5.1.7.2 The Member's right to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

4.5.1.7.3 The availability of assistance with filing;

4.5.1.7.4 The toll-free numbers to file oral grievances and appeals;

4.5.1.7.5 The Member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the Member may be liable for the cost of any continued benefits; and

4.5.1.7.6 The Provider's right to appeal the failure of the MCO to pay for or cover a service.

4.5.1.8 The MCO shall make available training to Providers in supporting and assisting Members in the Grievance System.

4.5.1.9 The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. [42 CFR 438.416(a)]

4.5.1.10 At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the Member, the dates received, the dates of each review, the dates of the grievance or appeal, the resolution and the date of resolution. [42 CFR 438.416(b)(1) - (6)]

4.5.1.11 In accordance with Exhibit O, the MCO shall provide reports on all actions related to Member grievances and appeals, including all matters handled by delegated entities, including timely processing, results, and frequency of grievance and appeals.

4.5.1.12 The MCO shall review Grievance System information as part of the State quality strategy and in accordance with this Agreement and 42 CFR 438.402. The MCO shall regularly review appeals data for process improvement which should include but not be limited to reviewing:

4.5.1.12.1 Reversed appeals for issues that could be addressed through improvements in the Prior Authorization process; and

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4.5.1.12.2 Overall appeals to determine further Member and Provider education in the Prior Authorization process.

4.5.1.13 The MCO shall make such information accessible to the State and available upon request to CMS. [42 CFR 438.416(c)]

4.5.2 Grievance Process

4.5.2.1 The MCO shall develop, implement, and maintain a Grievance Process that establishes the procedure for addressing Member grievances and which is compliant with RSA 420-J:5, 42 CFR 438 Subpart F and this Agreement.

4.5.2.2 The MCO shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the MCO either orally or in writing at any time. [42 CFR 438.402(c)(1)(i) - (ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

4.5.2.3 The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:

4.5.2.3.1 The quality of care or services provided;

4.5.2.3.2 Aspects of interpersonal relationships such as rudeness of a Provider or employee;

4.5.2.3.3 Failure to respect the Member's rights;

4.5.2.3.4 Dispute of an extension of time proposed by the MCO to make an authorization decision;

4.5.2.3.5 Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated; and

4.5.2.3.6 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits in accordance with 42 CFR 438, subpart K.

4.5.2.4 The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance or within fifty-nine (59) calendar days of receipt of the grievance for grievances extended for up to fourteen (14) calendar days even if the MCO does not have all the information necessary to make the decision, for one hundred percent (100%) of Members filing a grievance. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]

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4.5.2.5 The MCO may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:

4.5.2.5.1 If the Member requests the extension; or

4.5.2.5.2 If the MCO shows that there is need for additional information and that the delay is in the Member's interest (upon State request). [42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1)]

4.5.2.6 If the MCO extends the timeline for a grievance not at the request of the Member, the MCO shall:

4.5.2.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay; and

4.5.2.6.2 Give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1)]

4.5.2.7 [Amendment #6:] If the Member requests disenrollment, then the MCO shall resolve the grievance in time to permit the disenrollment (if approved) to be effective no later than the first day of the following second month in which the Member requests disenrollment. [42 CFR 438.56(d)(5)(ii); 42 CFR 438.56(e)(1); 42 CFR 438.228(a)]

4.5.2.8 The MCO shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

4.5.2.9 Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

4.5.3 Appeal Process

4.5.3.1 The MCO shall develop, implement, and maintain an Appeal Process that establishes the procedure for addressing Member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement. The MCO shall have only one (1) level of appeal for Members. [42 CFR 438.402(b); 42 CFR 438.228(a)]

4.5.3.2 The MCO shall permit a Member, or the Member's authorized representative, or a Provider acting on behalf of the Member and with the Member's written consent, to request an appeal

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orally or in writing of any MCO action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

4.5.3.3 The MCO shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's estate. [42 CFR 438.406(b)(6)]

4.5.3.4 [Amendment #5:] The MCO shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. [42 CFR 438.402(c)(2)(ii)] The MCO shall ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, ~~unless the Member or the authorized Provider requests expedited resolution.~~ [42 CFR 438.406(b)(3)] ~~An oral request for an appeal shall be followed by a written and signed appeal request unless the request is for an expedited resolution.~~ [42 CFR 438.402(c)(3)(ii)]

4.5.3.5 If DHHS receives a request to appeal an action of the MCO, DHHS shall forward relevant information to the MCO and the MCO shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

4.5.3.6 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

4.5.3.7 The MCO shall permit the Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing [42 CFR 438.406(b)(4)]. The MCO shall inform the Member of the limited time available for this in the case of expedited resolution.

4.5.3.8 [Amendment #10:] The MCO shall provide the Member and the Member's representative an opportunity to receive the Member's case file, ~~including medical records, and any other documents and records considered during the Appeal Process~~ free of charge prior to the resolution and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b) - (c)]

4.5.3.9 [Amendment #7:] The MCO may offer peer-to-peer review support, with a like clinician, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should

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occur in a timely manner, ~~and before the Provider seeks recourse through the Provider Appeal or State fair hearing process.~~

4.5.3.10 The MCO shall resolve one hundred percent (100%) of standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

4.5.3.11 The date of filing shall be considered either the date of receipt of an oral request for appeal or a written request for appeal from either the Member or Provider, whichever date is the earliest.

4.5.3.12 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits, in violation of 42 CFR 42 CFR 438, subpart K, may file an appeal.

4.5.3.13 If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the MCO's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)]

4.5.4 Actions

4.5.4.1 The MCO shall permit the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

4.5.4.1.1 Denial or limited authorization of a requested service, including the type or level of service;

4.5.4.1.2 Reduction, suspension, or termination of a previously authorized service;

4.5.4.1.3 [Amendment #5:] Denial, in whole or in part, of payment for a service, ~~except when denial for payment for a service is solely because the claim does not meet the definition of a "clean claim".~~ [42 CFR 438.400(b)(3)];

4.5.4.1.4 Failure to provide services in a timely manner, as defined by this Agreement;

4.5.4.1.5 Untimely service authorizations;

4.5.4.1.6 Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

4.5.4.1.7 At such times, if any, that DHHS has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one (1)

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MCO, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

4.5.5 Expedited Appeal

4.5.5.1 The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

4.5.5.2 The MCO shall inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals. [42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)]

4.5.5.3 The MCO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the MCO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

4.5.5.4 The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)] The MCO shall also make reasonable efforts to provide oral notice.

4.5.5.5 The date of filing of an expedited appeal shall be considered either an oral request for appeal or a written request from either the Member or Provider, whichever date is the earliest.

4.5.5.6 If the MCO extends the timeframes not at the request of the Member, it shall:

4.5.5.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay by providing a minimum of three (3) oral attempts to contact the Member at various times of the day, on different days within two (2) calendar days of the MCO's decision to extend the timeframe as detailed in He-W 506.08(j);

4.5.5.6.2 Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and

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inform the Member of the right to file a grievance if he or she disagrees with that decision;

4.5.5.6.3 Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i) - (iii); 42 CFR 438.408(b)(2)-(3)]

4.5.5.7 The MCO shall meet the timeframes above for one hundred percent (100%) of requests for expedited appeals.

4.5.5.8 The MCO shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

4.5.5.9 If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

4.5.5.10 The Member has a right to file a grievance regarding the MCOs denial of a request for expedited resolution. The MCO shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

4.5.6 Content of Notices

4.5.6.1 The MCO shall notify the requesting Provider, and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [42 CFR 438.210(c); 42 CFR 438.404] Such notice shall meet the requirements of 42 CFR 438.404, except that the notice to the Provider need not be in writing.

4.5.6.2 The MCO shall utilize NCQA compliant DHHS model notices for all adverse actions and appeals. MCO adverse action and appeal notices shall be submitted for DHHS review during the Readiness Review process. Each notice of adverse action shall contain and explain:

4.5.6.2.1 The action the MCO or its Subcontractor has taken or intends to take [42 CFR 438.404(b)(1)];

4.5.6.2.2 The reasons for the action, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action [42 CFR 438.404(b)(2)];

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4.5.6.2.3 The Member's or the Provider's right to file an appeal, including information on exhausting the MCO's one (1) level of appeal and the right to request a State fair hearing if the adverse action is upheld [42 CFR 438.404(b)(3); 42 CFR 438.402(b) - (c)];

4.5.6.2.4 Procedures for exercising Member's rights to file a grievance or appeal [42 CFR 438.404(b)(4)];

4.5.6.2.5 Circumstances under which expedited resolution is available and how to request it [42 CFR 438.404(b)(5)]; and

4.5.6.2.6 The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits [42 CFR 438.404(b)(6)].

4.5.6.3 The MCO shall ensure that all notices of adverse action be in writing and shall meet the following language and format requirements:

4.5.6.3.1 Written notice shall be translated for the Members who speak one (1) of the commonly encountered languages spoken by MCM Members (as defined by the State per 42 CFR 438.10(d));

4.5.6.3.2 Notice shall include language clarifying that oral interpretation is available for all languages and how to access it; and

4.5.6.3.3 Notices shall use easily understood language and format, and shall be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Members shall be informed that information is available in alternative formats and how to access those formats.

4.5.6.4 The MCO shall mail the notice of adverse action by the date of the action when any of the following occur:

4.5.6.4.1 The Member has died;

4.5.6.4.2 The Member submits a signed written statement requesting service termination;

4.5.6.4.3 The Member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction shall result;

4.5.6.4.4 The Member has been admitted to an institution where he or she is ineligible under the Medicaid State Plan for further services;

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4.5.6.4.5 The Member's address is determined unknown based on returned mail with no forwarding address;

4.5.6.4.6 The Member is accepted for Medicaid services by another state, territory, or commonwealth;

4.5.6.4.7 A change in the level of medical care is prescribed by the Member's physician;

4.5.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or

4.5.6.4.9 The transfer or discharge from a facility shall occur in an expedited fashion. [42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); section 1919(e)(7) of the Social Security Act; 42 CFR 483.12(a)(5)(i); 42 CFR 483.12(a)(5)(ii)]

4.5.7 Timing of Notices

4.5.7.1 For termination, suspension or reduction of previously authorized Medicaid Covered Services, the MCO shall provide Members written notice at least ten (10) calendar days before the date of action, except the period of advance notice shall be no more than five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable fraud by the Member. [42 CFR 438.404(c)(1); 42 CFR 431.211; 42 CFR 431.214]

4.5.7.2 In accordance with 42 CFR 438.404(c)(2), the MCO shall mail written notice to Members on the date of action when the adverse action is a denial of payment or reimbursement.

4.5.7.3 For standard service authorization denials or partial denials, the MCO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services. [42 CFR 438.210(d)(1); 42 CFR 438.404(c)(3)] An extension of up to an additional fourteen (14) calendar days is permissible, if:

4.5.7.3.1 The Member, or the Provider, requests the extension; or

4.5.7.3.2 The MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.210(d)(1)(i)-(ii); 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(4); 42 CFR 438.404(c)(6)]

4.5.7.4 When the MCO extends the timeframe, the MCO shall give the Member written notice of the reason for the decision to

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extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i)] Under such circumstance, the MCO shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii)]

4.5.7.5 For cases in which a Provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.5.7.6 The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest.

4.5.7.7 The MCO shall provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. [42 CFR 438.404(c)(5)]

4.5.8 Continuation of Benefits

4.5.8.1 The MCO shall continue the Member's benefits if:

4.5.8.1.1 The appeal is filed timely, meaning on or before the later of the following:

4.5.8.1.1.1 Within ten (10) calendar days of the MCO mailing the notice of action, or

4.5.8.1.1.2 The intended effective date of the MCO's proposed action;

4.5.8.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4.5.8.1.3 The services was ordered by an authorized Provider;

4.5.8.1.4 The authorization period has not expired;

4.5.8.1.5 The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice; and

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4.5.8.1.6 The Member requests extension of benefits, orally or in writing. [42 CFR 438.420(a); 42 CFR 438.420(b)(1) - (5); 42 CFR 438.402(c)(2)(ii)]

4.5.8.2 If the MCO continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one (1) of the following occurs:

4.5.8.2.1 The Member withdraws the appeal, in writing;

4.5.8.2.2 The Member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision regarding the Member's MCO appeal;

4.5.8.2.3 A State fair hearing decision adverse to the Member is made; or

4.5.8.2.4 The authorization expires or authorization service limits are met. [42 CFR 438.420(c)(1)-(3); 42 CFR 438.408(d)(2)]

4.5.8.3 If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the Member the amount paid for the services provided to the Member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services. [42 CFR 438.420(d); 42 CFR 431.230(b)]

4.5.8.4 A Provider acting as an authorized representative shall not request a Member's continuation of benefits pending appeal even with the Member's written consent.

4.5.9 Resolution of Appeals

4.5.9.1 The MCO shall resolve each appeal and provide notice, as expeditiously as the Member's health condition requires, within the following timeframes:

4.5.9.1.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services, a decision shall be made within thirty (30) calendar days after receipt of the appeal even if the MCO does not have all the information necessary to make the decision, unless the MCO notifies the Member that an extension is necessary to complete the appeal.

4.5.9.1.2 The MCO may extend the timeframes up to fourteen (14) calendar days if:

4.5.9.1.2.1. The Member requests an extension, orally or in writing, or

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4.5.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the Member's best interest; [42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1)]

4.5.9.1.3 If the MCO extends the timeframes not at the request of the Member then it shall:

4.5.9.1.3.1. Make reasonable efforts to give the Member prompt oral notice of the delay,

4.5.9.1.3.2. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1); 42 CFR 438.408(b)(3)]

4.5.9.2 Under no circumstances may the MCO extend the appeal determination beyond forty-five (45) calendar days from the day the MCO receives the appeal request even if the MCO does not have all the information necessary to make the decision.

4.5.9.3 The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

4.5.9.4 The MCO shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Provider or Member may obtain the Utilization Management clinical review or decision-making criteria. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2)]

4.5.9.5 For notice of an expedited resolution, the MCO shall provide written notice, and make reasonable efforts to provide oral notice. [42 CFR 438.408(d)(2)(ii)]

4.5.9.6 For appeals not resolved wholly in favor of the Member, the notice shall:

4.5.9.6.1 Include information on the Member's right to request a State fair hearing;

4.5.9.6.2 How to request a State fair hearing;

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4.5.9.6.3 Include information on the Member's right to receive services while the hearing is pending and how to make the request; and

4.5.9.6.4 Inform the Member that the Member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision upholds the MCO's action. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2)]

4.5.10 State Fair Hearing

4.5.10.1 The MCO shall inform Members regarding the State fair hearing process, including but not limited to Members' right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F.

4.5.10.2 The parties to the State fair hearing include the MCO as well as the Member and his or her representative or the representative of a deceased Member's estate.

4.5.10.3 The MCO shall ensure that Members are informed, at a minimum, of the following:

4.5.10.3.1 That Members shall exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with DHHS; and

4.5.10.3.2 That if a Member does not agree with the MCO's resolution of the appeal, the Member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date of the MCO's notice of the resolution of the appeal. [42 CFR.408(f)(2)]

4.5.10.4 If the Member requests a fair hearing, the MCO shall provide to DHHS and the Member, upon request, within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.5 A Member may request an expedited resolution of a State fair hearing if the Administrative Appeals Unit (AAU) determines that the time otherwise permitted for a State fair hearing could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function, and:

4.5.10.5.1 The MCO adversely resolved the Member's appeal wholly or partially; or

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4.5.10.5.2 The MCO failed to resolve the Member's expedited appeal within seventy-two (72) hours and failed to extend the seventy-two (72)-hour deadline in accordance with 42 CFR 408(c) and He-W 506.08(i).

4.5.10.6 If the Member requests an expedited State fair hearing, the MCO shall provide to DHHS and the Member, upon request within twenty-four (24) hours, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.7 If the AAU grants the Member's request for an expedited State fair hearing, then the AAU shall resolve the appeal within three (3) business days after the Unit receives from the MCO the case file and any other necessary information. [He-W 506.09(g)]

4.5.10.8 The MCO shall appear and defend its decision before the DHHS AAU. The MCO shall consult with DHHS regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate, at no additional cost. In the event the State fair hearing decision is appealed by the Member, the MCO shall provide all necessary support to DHHS for the duration of the appeal at no additional cost.

4.5.10.9 The DHHS AAU shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.5.11 Effect of Adverse Decisions of Appeals and Hearings

4.5.11.1 If the MCO or DHHS reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. [42 CFR 438.424(a)]

4.5.11.2 If the MCO or DHHS reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal or State fair hearing were pending, the MCO shall pay for those services. [42 CFR 438.424(b)]

4.5.12 Survival

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4.5.12.1 The obligations of the MCO to fully resolve all grievances and appeals, including but not limited to providing DHHS with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

4.6 Provider Appeals

4.6.1 General

4.6.1.1 The MCO shall develop, implement, and maintain a Provider Appeals Process under which Providers may challenge any Provider adverse action by the MCO, and access the State's fair hearing system in accordance with RSA 126-A:5, VIII.

4.6.1.2 The MCO shall provide to DHHS a complete description of its Provider Appeals Process, in writing, including all policies and procedures, notices and forms, of its proposed Provider Appeals Process for DHHS's review and approval during the Readiness Review period.

4.6.1.3 Any proposed changes to the Provider Appeals Process shall be approved by DHHS at least thirty (30) calendar days in advance of implementation.

4.6.1.4 The MCO shall clearly articulate its Provider Appeals Process in the MCO's Provider manual, and reference it in the Provider agreement.

4.6.1.5 The MCO shall ensure its Provider Appeals Process complies with the following general requirements:

4.6.1.5.1 Gives reasonable assistance to Providers requesting an appeal of a Provider adverse action;

4.6.1.5.2 Ensures that the decision makers involved in the Provider Appeals Process and their subordinates were not involved in previous levels of review or decision making of the Provider's adverse action;

4.6.1.5.3 Ensures that decision makers take into account all comments, documents, records, and other information submitted by the Provider to the extent such materials are relevant to the appeal; and

4.6.1.5.4 Advises Providers of any changes to the Provider Appeals Process at least thirty (30) calendar days prior to implementation.

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4.6.2 Provider Adverse Actions

4.6.2.1 The Provider shall have the right to file an appeal with the MCO and utilize the Provider Appeals Process for any adverse action, in accordance with RSA 126-A:5, VIII, except for Member appeals or grievances described in Section 4.5 (Member Grievances and Appeals). The Provider shall have the right to file an appeal within thirty (30) calendar days of the date of the MCO's notice of adverse action to the Provider. Reasons may include, but are not limited to:

4.6.2.1.1 Action against the Provider for reasons related to program integrity;

4.6.2.1.2 Termination of the Provider's agreement before the agreement period has ended for reasons other than when DHHS, MFCU or other government agency has required the MCO to terminate such agreement;

4.6.2.1.3 Denial of claims for services rendered that have not been filed as a Member appeal; and

4.6.2.1.4 Violation of the agreement between the MCO and the Provider.

4.6.2.2 The MCO shall not be precluded from taking an immediate adverse action even if the Provider requests an appeal; provided that, if the adverse action is overturned during the MCO's Provider Appeals Process or State fair hearing, the MCO shall immediately take all steps to reverse the adverse action within ten (10) calendar days.

4.6.3 Provider Appeal Process

4.6.3.1 The MCO shall provide written notice to the Provider of any adverse action, and include in its notice a description of the basis of the adverse action, and the right to appeal the adverse action.

4.6.3.2 Providers shall submit a written request for an appeal to the MCO, together with any evidence or supportive documentation it wishes the MCO to consider, within thirty (30) calendar days of:

4.6.3.2.1 The date of the MCO's written notice advising the Provider of the adverse action to be taken; or

4.6.3.2.2 The date on which the MCO should have taken a required action and failed to take such action.

4.6.3.3 The MCO shall be permitted to extend the decision deadline by an additional thirty (30) calendar days to allow the Provider to submit evidence or supportive documentation, and for other good cause determined by the MCO.

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4.6.3.4 The MCO shall ensure that all Provider Appeal decisions are determined by an administrative or clinical professional with expertise in the subject matter of the Provider Appeal.

4.6.3.5 The MCO may offer peer-to-peer review support, with a like clinician, upon request, for Providers who receive an adverse decision from the MCO. Any such peer-to-peer review should occur in a timely manner and before the Provider seeks recourse through the Provider Appeal or State fair hearing process.

4.6.3.6 The MCO shall maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, log records shall include:

4.6.3.6.1 General description of each appeal;

4.6.3.6.2 Name of the Provider;

4.6.3.6.3 Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and

4.6.3.6.4 Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

4.6.3.7 If the MCO fails to adhere to notice and timing requirements established in this Agreement, then the Provider is deemed to have exhausted the MCO's Appeals Process and may initiate a State fair hearing.

4.6.3.8 MCO Resolution of Provider Appeals

4.6.3.8.1 [Amendment 7] The MCO shall provide written notice of resolution of ~~the~~ ninety-five percent (95%) Provider appeal (Resolution Notice) within thirty (30) calendar days from either the date the MCO receives the appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which the Provider's evidence is received by the MCO.

4.6.3.8.2 The Resolution Notice shall include, without limitation:

4.6.3.8.2.1 The MCO's decision;

4.6.3.8.2.2 The reasons for the MCO's decision;

4.6.3.8.2.3 The Provider's right to request a State fair hearing in accordance with RSA 126-A:5, VIII; and

4.6.3.8.2.4 For overturned appeals, the MCO shall take all steps to reverse the adverse action within ten (10) calendar days.

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4.6.3.9 State Fair Hearing

4.6.3.9.1 The MCO shall inform its Participating Providers regarding the State fair hearing process consistent with RSA 126-A:5, VIII, including but not limited to how to obtain a State fair hearing in accordance with its informing requirements under this Agreement.

4.6.3.9.2 The parties to the State fair hearing include the MCO as well as the Provider.

4.6.3.9.3 The Participating Provider shall exhaust the MCO's Provider Appeals Process before pursuing a State fair hearing.

4.6.3.9.4 If a Participating Provider requests a State fair hearing, the MCO shall provide to DHHS and the Participating Provider, upon request, within three (3) business days, all MCO-held documentation related to the Provider Appeal, including but not limited to, any transcript(s), records, or written decision(s).

4.6.3.9.5 The MCO shall consult with DHHS regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and availability of the Medical Director and/or other staff as appropriate, at no additional cost.

4.6.3.9.6 The MCO shall appear and defend its decision before the DHHS AAU. Nothing in this Agreement shall preclude the MCO from representation by legal counsel.

4.6.3.9.7 The DHHS AAU shall notify the MCO of State fair hearing determinations within sixty (60) calendar days of the date of the MCO's Notice of Resolution.

4.6.3.9.8 The MCO shall:

4.6.3.9.8.1. Not object to the State intervening in any such appeal;

4.6.3.9.8.2. Be bound by the State fair hearing determination, whether or not the State fair hearing determination upholds the MCO's Final Determination; and

4.6.3.9.8.3. Take all steps to reverse any overturned adverse action within ten (10) calendar days.

4.6.3.9.9 Reporting

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4.6.3.9.9.1. The MCO shall provide to DHHS, as detailed in Exhibit O, Provider complaint and appeal logs. [42 CFR 438.66(c)(3)]

4.7 Access

4.7.1 **Provider Network**

4.7.1.1 The MCO shall implement written policies and procedures for selection and retention of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(a)]

4.7.1.2 The MCO shall develop and maintain a statewide Participating Provider network that adequately meets all covered medical, mental health, Substance Use Disorder and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple Providers and disciplines and Equal Access to services. In developing its network, the MCO shall consider the following:

4.7.1.2.1 Current and anticipated NH Medicaid enrollment;

4.7.1.2.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the covered NH population;

4.7.1.2.3 The number and type (in terms of training and experience and specialization) of Providers required to furnish the contracted services;

4.7.1.2.4 The number of network Providers limiting NH Medicaid patients or not accepting new or any NH Medicaid patients;

4.7.1.2.5 The geographic location of Providers and Members, considering distance, travel time, and the means of transportation ordinarily used by NH Members;

4.7.1.2.6 The linguistic capability of Providers to communicate with Members in non-English languages, including oral and American Sign Language;

4.7.1.2.7 The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions;

4.7.1.2.8 Adequacy of the primary care network to offer each Member a choice of at least two (2) appropriate PCPs that are accepting new Medicaid patients;

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4.7.1.2.9 Required access standards identified in this Agreement;
and

4.7.1.2.10 Required access standards set forth by the NHID,
including RSA. 420-J; and Admin Rule 2700.

4.7.1.3 The MCO shall meet the network adequacy standards
included in this Agreement in all geographic areas in which the MCO
operates for all Provider types covered under this Agreement.

4.7.1.4 The MCO shall ensure that services are as accessible to
Members in terms of timeliness, amount, duration and scope as those
that are available to Members covered by DHHS under FFS Medicaid
within the same service area.

4.7.1.5 The MCO shall ensure Participating Providers comply with
the accessibility standards of the ADA. Participating Providers shall
demonstrate physical access, reasonable accommodations, and
accessible equipment for all Members including those with physical
or cognitive disabilities. [42 CFR 438.206(c)(3)]

4.7.1.6 The MCO shall demonstrate that there are sufficient
Participating Indian Health Care Providers (IHCPs) in the
Participating Provider network to ensure timely access to services for
American Indians who are eligible to receive services. If Members are
permitted by the MCO to access out-of-state IHCPs, or if this
circumstance is deemed to be good cause for disenrollment, the MCO
shall be considered to have met this requirement. [42 CFR
438.14(b)(1); 42 CFR 438.14(b)(5)]

4.7.1.7 The MCO shall maintain an updated list of Participating
Providers on its website in a Provider Directory, as specified in
Section 4.4.1.5 (Provider Directory) of this Agreement.

4.7.2 Assurances of Adequate Capacity and Services

4.7.2.1 The MCO's network shall have Participating Providers in
sufficient numbers, and with sufficient capacity and expertise for all
Covered Services to meet the geographic standards in Section 4.7.3
(Time and Distance Standards), the timely provision of services
requirements in Section 4.7.5 (Timely Access to Service Delivery),
Equal Access, and reasonable choice by Members to meet their
needs [42 CFR 438.207(a)].

4.7.2.2 The MCO shall submit documentation to DHHS, in the
format and frequency specified by DHHS in Exhibit O, that fulfills the
following requirements:

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4.7.2.2.1 The MCO shall give assurances and provide supporting documentation to DHHS that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DHHS's standards for access and timeliness of care. [42 CFR 438.207(a); 42 CFR 438.68; 42 CFR 438.206(c)(1)].

4.7.2.2.2 The MCO offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Members for the service area. [42 CFR 438.207(b)(1)];

4.7.2.2.3 The MCO's Participating Provider network includes sufficient family planning Providers to ensure timely access to Covered Services. [42 CFR 438.206(b)(7)];

4.7.2.2.4 The MCO is complying with DHHS's requirements for availability, accessibility of services, and adequacy of the network including pediatric subspecialists as described in Section 4.7.5.10 (Access Standards for Children with Special Health Care Needs);

4.7.2.2.5 The MCO is complying with DHHS's requirements for Substance Use Disorder treatment services as specified in Section 4.11.6 (Substance Use Disorder) and mental health services as specified in Section 4.11.5 (Mental Health), including Providers required to reduce Psychiatric Boarding; and

4.7.2.2.6 The MCO demonstrates Equal Access to services for all populations in the MCM program, as described in Section 4.7.5 (Timely Access to Service Delivery).

4.7.2.3 To permit DHHS to determine if access to private duty nursing services is increasing, as indicated by DHHS in Exhibit O, the MCO shall provide to DHHS the following information:

4.7.2.3.1 The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

4.7.2.3.2 The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

4.7.2.4 The MCO shall submit documentation to DHHS to demonstrate that it maintains an adequate network of Participating Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area, in accordance with Exhibit O:

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4.7.2.4.1 During the Readiness Review period, prior to the Program Start Date;

4.7.2.4.2 [Amendment #5:] Annually ~~Semi-annually~~; and

4.7.2.4.3 At any time there has been a significant change (as defined by DHHS) in the entity's operations that would affect adequate capacity and services, including but not limited to changes in services, benefits, geographic service area, or payments; and/or enrollment of a new population in the MCO. [42 CFR 438.207(b) - (c)]

4.7.2.5 For purposes of providing assurances of adequate capacity and services, the MCO shall base the anticipated number of Members on the "NH MCM Fifty Percent (50%) Population Estimate by Zip Code" report provided by DHHS.

4.7.3 Time and Distance Standards

4.7.3.1 At a minimum, the MCO shall meet the geographic access standards described in the Table below for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members. [42 CFR 438.68(b)(1)(i) - (viii); 42 CFR 438.68(b)(3)]

Geographic Access Standards	
Provider/Service	Requirement
PCPs (Adult and Pediatric)	Two (2) within forty (40) driving minutes or fifteen (15) driving miles
Adult Specialists	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Pediatric Specialists	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
OB/GYN Providers	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospitals	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Mental Health Providers (Adult and Pediatric)	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
Pharmacies	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles

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Geographic Access Standards	
Provider/Service	Requirement
Tertiary or Specialized Services (Trauma, Neonatal, etc.)	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
Individual/Group MLADCs	One (1) within forty-five (45) minutes or fifteen (15) miles
Substance Use Disorder Programs	One (1) within sixty (60) minutes or forty-five (45) miles.
Adult Medical Day Care	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospice	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Office-based Physical Therapy/Occupational Therapy/Speech Therapy	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

4.7.3.2 [Amendment #5:] The MCO shall report annually ~~semi-annually~~ how specific provider types meet the time and distance standards for Members in each county within NH in accordance with Exhibit O.

4.7.3.3 DHHS shall continue to assess where additional access requirements, whether time and distance or otherwise, shall be incorporated (for example, to ensure appropriate access to home health services). DHHS may provide additional guidance to the MCO regarding its network adequacy requirements in accordance with Members' ongoing access to care needs.

4.7.3.3.1 [Amendment #8:] The MCO shall contract with qualified Substance Use Disorder Providers who request to join its Participating Provider network as defined in Sections 2.1.89 and 2.1.119.1 of this Agreement pending the Substance Use Disorder Provider's agreement to the terms of the MCO's contract.

4.7.3.4 Additional Provider Standards

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Provider/Service	Requirement
MLADCs	The MCO's Participating Provider Network shall include seventy percent (70%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Opioid Treatment Programs (OTPs)	The MCO's Participating Provider Network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Buprenorphine Prescribers	The Network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Residential Substance Use Disorder Treatment Programs	The Network shall include fifty percent (50%) of all such Providers licensed and practicing in NH and no less than two (2) in any public health region unless there are less than two (2) such Providers in the region
Peer Recovery Programs	The MCO's Participating Provider Network shall include one hundred percent (100%) of all such willing Programs in NH

4.7.4 Standards for Geographic Accessibility

4.7.4.1 The MCO may request exceptions from the above-identified network standards after demonstrating its efforts to create a sufficient network of Participating Providers to meet these standards. DHHS reserves the right to approve or disapprove these requests, at its discretion.

4.7.4.2 Should the MCO, after good faith negotiations with Provider(s), be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, with the assistance of DHHS and after good faith negotiations, continue to be unable to meet geographic and timely access to service delivery standards, then for a period of up to sixty (60) calendar days after start date, Liquidated Damages, as described in Section 5.5.2 (Liquidated Damages) shall not apply.

4.7.4.3 Except within a period of sixty (60) calendar days after the start date where Liquidated Damages shall not apply, should the MCO, after good faith negotiations, be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable,

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after good faith negotiations with the assistance of DHHS, continue to be unable to meet geographic and timely access to service delivery standards DHHS may, at its discretion, provide temporary exemption to the MCO from Liquidated Damages.

4.7.4.4 At any time the provisions of this section may apply, the MCO shall work with DHHS to ensure that Members have access to needed services.

4.7.4.5 The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the Participating Provider network to ensure that necessary admissions can be made.

4.7.4.6 Exceptions

4.7.4.6.1 The MCO may request exceptions, via a Request for Exception, from the network adequacy standards after demonstrating its efforts to create a sufficient network of Participating Providers to meet these standards. [42 CFR 438.68(d)(1)] DHHS may grant the MCO an exception in the event that:

4.7.4.6.1.1. The MCO demonstrates that an insufficient number of qualified Providers or facilities that are willing to contract with the MCO are available to meet the network adequacy standards in this Agreement and as otherwise defined by the NHID and DHHS;

4.7.4.6.1.2. The MCO demonstrates, to the satisfaction of DHHS, that the MCO's failure to develop a Participating Provider network that meets the requirements is due to the refusal of a Provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

4.7.4.6.1.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from a Participating Provider that is a physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist, or other behavioral health specialists licensed by the NH Board of Medicine. [RSA 167:4-d]

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4.7.4.7 The MCO is permitted to use telemedicine as a tool for ensuring access to needed services in accordance with telemedicine coverage policies reviewed and approved by DHHS, but the MCO shall not use telemedicine to meet the State's network adequacy standards unless DHHS has specifically approved a Request for Exception.

4.7.4.8 The MCO shall report on network adequacy and exception requests in accordance with Exhibit O.

4.7.5 Timely Access to Service Delivery

4.7.5.1 The MCO shall meet the following timely access standards for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members.

4.7.5.2 The MCO shall make Covered Services available for Members twenty-four (24) hours a day, seven (7) days a week, when Medically Necessary. [42 CFR 438.206(c)(1)(iii)]

4.7.5.3 The MCO shall require that all Participating Providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial Members or are comparable to Medicaid FFS patients, if the Provider serves only Medicaid Members. [42 CFR 438.206(c)(1)(ii)].

4.7.5.4 The MCO shall encourage Participating Providers to offer after-hours office care in the evenings and on weekends.

4.7.5.5 The MCO's network shall meet minimum timely access to care and services standards as required per 42 CFR 438.206(c)(1)(i). Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

4.7.5.6 The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

4.7.5.6.1 Non-Symptomatic Office Visits (i.e., preventive care) shall be available from the Member's PCP or another Provider within forty-five (45) calendar days.

4.7.5.6.2 A Non-Symptomatic Office Visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

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4.7.5.6.3 Non-Urgent, Symptomatic Office Visits (i.e., routine care) shall be available from the Member's PCP or another Provider within ten (10) calendar days. A Non-Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms not requiring immediate attention.

4.7.5.6.4 Urgent, Symptomatic Office Visits shall be available from the Member's PCP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

4.7.5.6.5 Transitional Health Care shall be available from a primary care or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.6.6 Transitional Home Care shall be available with a home care nurse, licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or Specialty Care Provider or as part of the discharge plan.

4.7.5.7 [Amendment #7:] The MCO shall establish mechanisms to ensure that Participating Providers comply with the timely access standards. The MCO shall regularly monitor its network to determine compliance with timely access and shall provide an annual ~~a semi-annual~~ report to DHHS documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v), in accordance with Exhibit O.

4.7.5.8 The MCO shall monitor waiting times for obtaining appointments with approved CMH Programs and report case details on a semi-annual basis.

4.7.5.9 The MCO shall develop and implement a CAP if it or its Participating Providers fail to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

4.7.5.10 Access Standards for Children with Special Health Care Needs

4.7.5.10.1 The MCO shall contract with specialists that have pediatric expertise where the need for pediatric specialty care significantly differs from adult specialty care.

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4.7.5.10.2 In addition to the "specialty care" Provider network adequacy requirements, the MCO shall contract with the following pediatric specialists:

- 4.7.5.10.2.1. Pediatric Critical Care;
- 4.7.5.10.2.2. Pediatric Child Development ;
- 4.7.5.10.2.3. Pediatric Genetics;
- 4.7.5.10.2.4. Pediatric Physical Medicine and Rehabilitation;
- 4.7.5.10.2.5. Pediatric Ambulatory Tertiary Care ;
- 4.7.5.10.2.6. Neonatal-Perinatal Medicine;
- 4.7.5.10.2.7. Pediatrics-Adolescent Medicine; and
- 4.7.5.10.2.8. Pediatric Psychiatry.

4.7.5.11 The MCO shall have adequate networks of pediatric Providers, sub-specialists, children's hospitals, pediatric regional centers and ancillary Providers to provide care to Children with Special Health Care Needs.

4.7.5.12 The MCO shall specify, in their listing of mental health and Substance Use Disorder Provider directories, which Providers specialize in children's services.

4.7.5.13 The MCO shall ensure that Members have access to specialty centers in and out of NH for diagnosis and treatment of rare disorders.

4.7.5.14 The MCO shall permit a Member who meets the definition of Children with Special Health Care Needs following plan enrollment and who requires specialty services to request approval to see a Non-Participating Provider to provide those services if the MCO does not have a Participating specialty Provider with the same level of expertise available.

4.7.5.15 The MCO shall develop and maintain a program for Children with Special Health Care Needs, which includes, but is not limited to methods for ensuring and monitoring timely access to pediatric specialists, subspecialists, ancillary therapists and specialized equipment and supplies; these methods may include standing referrals or other methods determined by the MCO.

4.7.5.16 The MCO shall ensure PCPs and specialty care Providers are available to provide consultation to DCYF regarding medical and

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psychiatric matters for Members who are children in State custody/guardianship.

4.7.5.17 Access Standards for Behavioral Health

4.7.5.17.1 The MCO shall have in its network the capacity to ensure that Transitional Health Care by a Provider shall be available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.17.2 Emergency medical and behavioral health care shall be available twenty-four (24) hours a day, seven (7) days a week. Behavioral health care shall be available, and the MCO shall have in its network the capacity to ensure that waiting times for appointments and/or service availability do not exceed the following:

4.7.5.17.2.1. Within six (6) hours for a non-life threatening emergency;

4.7.5.17.2.2. Within forty-eight (48) hours for urgent care; and

4.7.5.17.2.3. Within ten (10) business days for a routine office visit appointment.

4.7.5.17.3 American Society of Addiction Medicine (ASAM) Level of Care

4.7.5.17.3.1. The MCO shall ensure Members timely access to care through a network of Participating Providers in each ASAM Level of Care. During the Readiness Review process and in accordance with Exhibit O:

4.7.5.17.3.1.1 The MCO shall submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of Substance Use Disorder service Providers so that services are accessible without unreasonable delays; and

4.7.5.17.3.1.2 The MCO shall have a specified number of Providers able to provide services at each level of care required; if supply precludes compliance, the MCO shall notify DHHS and, within thirty (30) calendar days, submit an updated plan that identifies the specific steps that shall be taken

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to increase capacity, including milestones by which to evaluate progress.

4.7.5.18 The MCO shall ensure that Providers under contract to provide Substance Use Disorder services shall respond to inquiries for Substance Use Disorder services from Members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The Substance Use Disorder Provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the Member or referring agency, but not later than two (2) business days following the date of first contact.

4.7.5.19 The MCO shall ensure that Members who have screened positive for Substance Use Disorder services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment and no later than (3) business days after admission.

4.7.5.20 The MCO shall ensure that Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed until such a time that the Member is accepted and starts receiving services by the receiving agency. Members identified for partial hospitalization or rehabilitative residential services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed.

4.7.5.21 If the type of service identified in the ASAM Level of Care Assessment is not available from the Provider that conducted the initial assessment within forty-eight (48) hours, the MCO shall ensure that the Provider provides interim Substance Use Disorder services until such a time that the Member starts receiving the identified level of care. If the type of service is not provided by the ordering Provider than the MCO is responsible for making a closed loop referral for that type of service (for the identified level of care) within fourteen (14) business days from initial contact and to provide interim Substance Use Disorder services until such a time that the Member is accepted and starts receiving services by the receiving agency.

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4.7.5.22 When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the Member's choice, Members being provided interim services shall be reassessed for ASAM level of care.

4.7.5.23 The MCO shall ensure that pregnant women are admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the MCO is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours, the MCO shall:

4.7.5.23.1 Assist the pregnant woman with identifying alternative Providers and with accessing services with these Providers. This assistance shall include actively reaching out to identify Providers on the behalf of the Member;

4.7.5.23.2 Provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week; Recovery support services as needed by the Member; and daily calls to the Member to assess and respond to any emergent needs.

4.7.5.24 Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.

4.7.6 Women's Health

4.7.6.1 The MCO shall provide Members with direct access to a women's health specialist within the network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].

4.7.6.2 The MCO shall provide access to Family Planning Services as defined in Section 2.1.47 (Definitions) to Members without the need for a referral or prior-authorization. Additionally, Members shall be able to access these services by Providers whether they are in or out of the MCO's network.

4.7.6.3 Enrollment in the MCO shall not restrict the choice of the Provider from whom the Member may receive Family Planning Services and supplies. [Section 1902(a)(23) of the Social Security Act; 42 CFR 431.51(b)(2)]

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4.7.6.4 The MCO shall only provide for abortions in the following situations:

4.7.6.4.1 If the pregnancy is the result of an act of rape or incest; or

4.7.6.4.2 In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition, caused by, or arising from, the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. [42 CFR 441.202; Consolidated Appropriations Act of 2008]

4.7.6.5 The MCO shall not provide abortions as a benefit, regardless of funding, for any reasons other than those identified in this Agreement.

4.7.7 Access to Special Services

4.7.7.1 The MCO shall ensure Members have access to DHHS-designated Level I and Level II Trauma Centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's service area or in close proximity to such service area. The MCO shall have written, out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a Trauma Center in its network.

4.7.7.2 The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, cranio-facial and congenital anomalies, home health agencies, and hospice programs. To the extent that the above specialty services are available within the State, the plan shall not exclude NH Providers from its network if the negotiated rates are commercially reasonable.

4.7.7.3 The MCO shall only pay for organ transplants when the Medicaid State Plan provides, and the MCO follows written standards that provide for similarly situated Members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Members. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act]

4.7.7.4 The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available.

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The MCO shall not exclude NH Providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

4.7.8 Non-Participating Providers

4.7.8.1 If the MCO's network is unable to provide necessary medical, behavioral health or other services covered under the Agreement to a particular Member, the MCO shall adequately and in a timely manner cover these services for the Member through Non-Participating Providers, for as long as the MCO's Participating Provider network is unable to provide them. [42 CFR 438.206(b)(4)].

4.7.8.2 The MCO shall inform the Non-Participating Provider that the Member cannot be balance billed.

4.7.8.3 The MCO shall coordinate with Non-Participating Providers regarding payment utilizing a single case agreement. For payment to Non-Participating Providers, the following requirements apply:

4.7.8.3.1 If the MCO offers the service through a Participating Provider(s), and the Member chooses to access non-emergent services from a Non-Participating Provider, the MCO is not responsible for payment.

4.7.8.3.2 If the service is not available from a Participating Provider and the Member requires the service and is referred for treatment to a Non-Participating Provider, the payment amount is a matter between the MCO and the Non-Participating Provider.

4.7.8.4 The MCO shall ensure that cost to the Member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

4.7.9 Access to Providers During Transitions of Care

4.7.9.1 The MCO shall use a standard definition of "Ongoing Special Condition" which shall be defined as follows:

4.7.9.1.1 In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

4.7.9.1.2 In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

4.7.9.1.3 In the case of pregnancy, pregnancy from the start of the second trimester.

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4.7.9.1.4 In the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

4.7.9.1.5 In the case of a child with Special Health Care Needs as defined in Section 4.10.3 (Priority Populations).

4.7.9.2 The MCO shall permit that, in the instances when a Member transitions into the MCO from FFS Medicaid, another MCO (including one that has terminated its agreement with DHHS) or another type of health insurance coverage and:

4.7.9.2.1 The Member is in ongoing course of treatment, has an Ongoing Special Condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), regardless of whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first;

4.7.9.2.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.2.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.3 The MCO shall permit that, in instances when a Member with an Ongoing Special Condition transitions into the MCO from FFS Medicaid or another MCO and at the time has a currently prescribed medication, the MCO shall cover such medications for ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first.

4.7.9.4 The MCO shall permit that, in instances in which a Provider in good standing leaves an MCO's network and:

4.7.9.4.1 The Member is in ongoing course of treatment, has a special condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days;

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4.7.9.4.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.4.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.5 The MCO shall maintain a transition plan providing for Continuity of Care in the event of Agreement termination, or modification limiting service to Members, between the MCO and any of its contracted Providers, or in the event of site closing(s) involving a PCP with more than one (1) location of service. The transition plan shall describe how Members shall be identified by the MCO and how Continuity of Care shall be provided.

4.7.9.6 The MCO shall provide written notice of termination of a Participating Provider to all affected Members, defined as those who:

4.7.9.6.1 Have received services from the terminated Provider within the sixty (60)-day period immediately preceding the date of the termination; or

4.7.9.6.2 Are assigned to receive primary care services from the terminated Provider.

4.7.9.7 [Amendment #5:] The MCO shall make a good faith effort to give written notice of termination of a contracted provider, as follows:

4.7.9.7.1 [Amendment #5:] Written notice to DHHS, the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination; and

4.7.9.7.2 [Amendment #5:] Written notice to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, the later of:

4.7.9.7.2.1. [Amendment #5:] Thirty (30) calendar days prior to the effective date of the termination; or

4.7.9.7.2.2. [Amendment #5:] Fifteen (15) calendar days after receipt or issuance of the termination notice by the terminated provider.

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4.7.9.7.2.3. [Amendment #5:] The MCO shall have a transition plan in place for affected Members described in Section 4.7.9.7 within three (3) calendar days prior to the effective date of the termination.

~~[Base Contract:] notify DHHS and affected Members in writing of a Provider termination. The notice shall be provided by the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination. Within three (3) calendar days prior to the effective date of the termination the MCO shall have a transition plan in place for all affected Members.~~

4.7.9.8 In addition to notification of DHHS of provider terminations, the MCO shall provide reporting in accordance with Exhibit O.

4.7.9.9 If a Member is in a prior authorized ongoing course of treatment with a Participating Provider who becomes unavailable to continue to provide services, the MCO shall notify the Member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a transition plan for the affected Member.

4.7.9.10 If the terminated Provider is a PCP to whom the MCO Members are assigned, the MCO shall:

4.7.9.10.1 Describe in the notice to Members the procedures for selecting an alternative PCP;

4.7.9.10.2 Explain that the Member shall be assigned to an alternative PCP if they do not actively select one; and

4.7.9.10.3 Ensure the Member selects or is assigned to a new PCP within thirty (30) calendar days of the date of notice to the Member.

4.7.9.11 If the MCO is receiving a new Member it shall facilitate the transition of the Member's care to a new Participating Provider and plan a safe and medically appropriate transition if the Non-Participating Provider refuses to contract with the MCO.

4.7.9.12 The MCO shall actively assist Members in transitioning to a Participating Provider when there are changes in Participating Providers, such as when a Provider terminates its contract with the MCO. The Member's Care Management team shall provide this assistance to Members who have chronic or acute medical or behavioral health conditions, and Members who are pregnant.

4.7.9.13 To minimize disruptions in care, the MCO shall:

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4.7.9.13.1 With the exception of Members in their second or third trimester of pregnancy, provide continuation of the terminating Provider for up to ninety (90) calendar days or until the Member may be reasonably transferred to a Participating Provider without disruption of care, whichever is less; and

4.7.9.13.2 For Members in their second or third trimester of pregnancy, permit continued access to the Member's prenatal care Provider and any Provider currently treating the Member's chronic or acute medical or behavioral health condition or currently providing LTSS, through the postpartum period.

4.7.10 Second Opinion

4.7.10.1 The MCO shall provide for a Second Opinion from a qualified health care professional within the Participating Provider network, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member [42 CFR 438.206(b)(3)]. The MCO shall clearly state its procedure for obtaining a Second Opinion in its Member Handbook.

4.7.11 Provider Choice

4.7.11.1 The MCO shall permit each Member to choose his or her Provider to the extent possible and appropriate [42 CFR 438.3(l)].

4.8 Utilization Management

4.8.1 Policies and Procedures

4.8.1.1 The MCO's policies and procedures related to the authorization of services shall be in compliance with all applicable laws and regulations including but not limited to 42 CFR 438.210 and RSA Chapter 420-E.

4.8.1.2 The MCO shall ensure that the Utilization Management program assigns responsibility to appropriately licensed clinicians, including but not limited to physicians, nurses, therapists, and behavioral health Providers (including Substance Use Disorder professionals).

4.8.1.3 Amount, Duration, and Scope

4.8.1.3.1 The MCO shall ensure that each service provided to adults is furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under FFS Medicaid. [42 CFR 438.210(a)(2)]

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4.8.1.3.2 The MCO shall also provide services for Members under the age of twenty-one (21) to the same extent that services are furnished to individuals under the age of twenty-one (21) under FFS Medicaid. [42 CFR 438.210(a)(2)] Services shall be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. [42 CFR 438.210(a)(3)(i)]

4.8.1.3.3 Authorization duration for certain Covered Services shall be as follows:

4.8.1.3.3.1. Private duty nursing authorizations shall be issued for no less than six (6) months unless the Member is new to the private duty nursing benefit. Initial authorizations for Members new to the private duty nursing benefit shall be no less than two (2) weeks;

4.8.1.3.3.1.1 [Amendment #9] [Amendment #8:] [Amendment #7:] For the period January 1, 2022 through the end of the COVID-19 Public Health Emergency June 30 December 31, 2022, in an effort to ensure that Members receive timely, necessary, and appropriate medical care requiring covered private duty nursing services that might otherwise go unmet due to expired authorizations and to ensure that providers are not penalized for providing said timely, necessary and appropriate medical care, the MCO shall not deny a private duty nursing provider's reimbursement for covered services rendered up to forty-five (45) days after the service authorization expires.

4.8.1.3.3.2. Personal Care Attendant (PCA) authorizations shall be issued for no less that one (1) year unless the Member is new to the PCA benefit. Initial authorizations for Members new to the PCA benefit shall be no less than three (3) months.

4.8.1.3.3.3. Occupational therapy, physical therapy, and speech therapy authorizations that exceed the service limit of twenty (20) visits for each type of therapy shall be issued for no less than three (3) months initially. Subsequent authorizations for continuation of therapy services shall be issued for no less than six (6) months if the therapy is for habilitative purposes directed at functional impairments.

4.8.1.4 Written Utilization Management Policies

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4.8.1.4.1 The MCO shall develop, operate, and maintain a Utilization Management program that is documented through a program description and defined structures, policies, and procedures that are reviewed and approved by DHHS. The MCO shall ensure that the Utilization Management Program has criteria and policies that:

4.8.1.4.1.1. Are practicable, objective and based on evidence-based criteria, to the extent possible;

4.8.1.4.1.2. Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the MCO's service area, and are consistent with the Practice Guidelines described in Section 4.8.2 (Practice Guidelines and Standards);

4.8.1.4.1.3. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (DHHS shall approve any changes to the clinical criteria before the criteria are utilized);

4.8.1.4.1.4. Are applied based on individual needs and circumstances (including social determinants of health needs);

4.8.1.4.1.5. Are applied based on an assessment of the local delivery system;

4.8.1.4.1.6. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

4.8.1.4.1.7. Conform to the standards of NCQA Health Plan Accreditation as required by Section 4.12.2 (Health Plan Accreditation).

4.8.1.4.2 The MCO's written Utilization Management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Such policies, procedures and criteria shall address, at a minimum:

4.8.1.4.2.1. Second Opinion programs;

4.8.1.4.2.2. Pre-hospital admission certification;

4.8.1.4.2.3. Pre-inpatient service eligibility certification;

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4.8.1.4.2.4. Concurrent hospital review to determine appropriate length of stay;

4.8.1.4.2.5. The process used by the MCO to preserve confidentiality of medical information.

4.8.1.4.3 Clinical review criteria and changes in criteria shall be communicated to Participating Providers and Members at least thirty (30) calendar days in advance of the changes.

4.8.1.4.4 The Utilization Management Program descriptions shall be submitted by the MCO to DHHS for review and approval prior to the Program Start Date.

4.8.1.4.5 Thereafter, the MCO shall report on the Utilization Management Program as part of annual reporting in accordance with Exhibit O.

4.8.1.4.6 The MCO shall communicate any changes to Utilization Management processes at least thirty (30) calendar days prior to implementation.

4.8.1.4.7 The MCO's written Utilization Management policies, procedures, and criteria shall be made available upon request to DHHS, Participating Providers, and Members.

4.8.1.4.8 The MCO shall provide the Medical Management Committee (or the MCO's otherwise named committee responsible for medical Utilization Management) reports and minutes in accordance with Exhibit O. [42 CFR 438.66 (c)(7)]

4.8.1.5 Service Limit

4.8.1.5.1 The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity [42 CFR 438.210(a)(4)(i)]; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. [42 CFR 438.210(a)(4)(ii)(A)]

4.8.1.5.2 The MCO may place appropriate limits on a service for utilization control, provided:

4.8.1.5.2.1. The services supporting Members with ongoing or Chronic Conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports [42 CFR 438.210(a)(4)(ii)(B)]. This includes allowance for up to six (6) skilled nursing visits per benefit period without a Prior Authorization; and

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4.8.1.5.2.2. Family Planning Services are provided in a manner that protects and enables the Member's freedom to choose the method of Family Planning to be used. [42 CFR 438.210(a)(4)(ii)(C)]

4.8.1.6 Prior Authorization

4.8.1.6.1 The MCO and, if applicable, its Subcontractors shall have in place and follow written policies and procedures as described in the Utilization Management policies for processing requests for initial and continuing authorizations of services and including conditions under which retroactive requests shall be considered. Any Prior Authorization for Substance Use Disorder shall comply with RSA 420-J:17 and RSA 420-J:18 as described in Section 4.11.6.15 (Limitations on Prior Authorization Requirements). [42 CFR 438.210(b)(1)]

4.8.1.6.2 Authorizations shall be based on a comprehensive and individualized needs assessment that addresses all needs including social determinants of health and a subsequent person-centered planning process. [42 CFR 438.210(b)(2)(iii)] The MCO's Prior Authorization requirements shall comply with parity in mental health and Substance Use Disorder, as described in Section 4.11.4.4 (Restrictions on Treatment Limitations). [42 CFR 438.910(d)]

4.8.1.6.3 The MCO shall use the NH MCM standard Prior Authorization form. The MCO shall also work in good faith with DHHS, as initiated by DHHS, to develop other Prior Authorization forms with consistent information and documentation requirements from Providers wherever feasible. Providers shall be able to submit the Prior Authorizations forms electronically, by mail, or fax.

4.8.1.6.4 The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including but not limited to interrater reliability monitoring, and consult with the requesting Provider when appropriate and at the request of the Provider submitting the authorization [42 CFR 438.210(b)(2)(i)-(ii)].

4.8.1.6.5 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. [42 CFR 438.210(b)(3)]

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4.8.1.6.6 The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Member.

4.8.1.6.7 The MCO shall comply with all relevant federal regulations regarding inappropriate denials or reductions in care. [42 CFR 438.210(a)(3)(ii)]

4.8.1.6.8 The MCO shall issue written denial notices within timeframes specified by federal regulations and this Agreement.

4.8.1.6.9 The MCO shall permit Members to appeal service determinations based on the Grievance and Appeal Process required by federal law and regulations and this Agreement.

4.8.1.6.10 Compensation to individuals or entities that conduct Utilization Management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member. [42 CFR 438.210(e)]

4.8.1.6.11 Medicaid State Plan services and/or pharmaceutical Prior Authorizations, including those for specialty drugs, in place at the time a Member transitions to an MCO shall be honored for ninety (90) calendar days or until completion of a medical necessity review, whichever comes first.

4.8.1.6.12 The MCO shall, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.

4.8.1.6.13 Upon receipt of Prior Authorization information from DHHS, the new MCO shall honor Prior Authorizations in place by the former MCO as described in Section 4.7.9. (Access to Providers During Transitions of Care). The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 4.8.4.2 (Urgent Determinations and Covered/Extended Services).

4.8.1.6.14 ~~[Amendment #9] Intentionally left blank. The MCO shall also, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.~~

4.8.1.6.15 In the event that the Prior Authorization specifies a specific Provider, that MCO shall continue to utilize that Provider, regardless of whether the Provider is a Participating Provider, until such time as services are available in the MCO's network.

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4.8.1.6.16 The MCO shall ensure that the Member's needs are met continuously and shall continue to cover services under the previously issued Prior Authorization until the MCO issues new authorizations that address the Member's needs.

4.8.1.6.17 The MCO shall ensure that Subcontractors or any other party performing utilization review are licensed in NH in accordance with Section 3.14.2 (Contracts with Subcontractors).

4.8.1.6.18 [Amendment #8:] Beginning July 1, 2022, the MCO shall ensure that Subcontractors or any other party performing utilization reviews applicable to inpatient psychiatric treatment at New Hampshire Hospital and other State determined IMDs for mental illness, conduct authorization for services as follows:

4.8.1.6.18.1. [Amendment #8:] For a Member's initial admission, an automatic five (5) business days (excluding holidays) shall be authorized for the Member's initial involuntary emergency psychiatric admission to an IMD facility.

4.8.1.6.18.2. [Amendment #8:] Reauthorization of the Member's continuous admission, shall be rendered promptly within 24 hours of the request for reauthorization of the initial involuntary emergency psychiatric admission.

4.8.2 Practice Guidelines and Standards

4.8.2.1 The MCO shall adopt evidence-based clinical Practice Guidelines in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines adopted by the MCO shall:

4.8.2.1.1 Be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field,

4.8.2.1.2 Consider the needs of the MCO's Members,

4.8.2.1.3 Be adopted in consultation with Participating Providers, and

4.8.2.1.4 Be reviewed and updated periodically as appropriate. [42 CFR 438.236(b)(1)-(3); 42 CFR 438.236(b)(4)]

4.8.2.2 The MCO shall develop Practice Guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

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4.8.2.3 The MCO shall adopt Practice Guidelines consistent with the standards of care and evidence-based practices of specific professional specialty groups, as identified by DHHS. These include, but are not limited to:

4.8.2.3.1 ASAM, as further described in Section 4.11.6.7 (Substance Use Disorder Clinical Evaluations and Treatment Plans);

4.8.2.3.2 The recommendations of the U.S. Preventive Services Task Force for the provision of primary and secondary care to adults, rated A or B;

4.8.2.3.3 The preventative services recommended by the AAP Bright Futures program; and

4.8.2.3.4 The Zero Suicide Consensus Guide for Emergency Departments²⁰

4.8.2.4 The MCO may substitute generally recognized, accepted guidelines to replace the U.S. Preventive Services Task Force and AAP Bright Futures program requirements, provided that the MCO meets all other Practice Guidelines requirements indicated within this Section 4.8.2 (Practice Guidelines and Standards) of the Agreement and that such substitution is reviewed by DHHS prior to implementation.

4.8.2.5 The MCO shall disseminate Practice Guidelines to DHHS and all affected Providers and make Practice Guidelines available, including but not limited to the MCO's website, and, upon request, to Members and potential Members. [42 CFR 438.236(c)]

4.8.2.6 The MCO's decisions regarding Utilization Management, Member education, and coverage of services shall be consistent with the MCO's clinical Practice Guidelines. [42 CFR 438.236(d)]

4.8.3 Medical Necessity Determination

4.8.3.1 The MCO shall specify what constitutes "Medically Necessary" services in a manner that:

4.8.3.1.1 Is no more restrictive than the NH DHHS FFS Medicaid program including quantitative and non-quantitative treatment limits, as indicated in State laws and regulations, the Medicaid State Plan, and other State policies and procedures [42 CFR 438.210(a)(5)(i)]; and

²⁰ Suicide Prevention Resource Center, "Care for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments"

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4.8.3.1.2 Addresses the extent to which the MCO is responsible for covering services that address [42 CFR 438.210(a)(5)(ii)(A)-(C)]:

4.8.3.1.2.1. The prevention, stabilization, diagnosis, and treatment of a Member's diseases, condition, and/or disorder that results in health impairments and/or disability;

4.8.3.1.2.2. The ability for a Member to achieve age-appropriate growth and development; and

4.8.3.1.2.3. The ability for a Member to attain, maintain, or regain functional capacity.

4.8.3.2 For Members twenty-one (21) years of age and older, "Medically Necessary" shall be as defined in Section 2.1.74.2 (Definitions).

4.8.3.3 For Members under twenty-one (21) years of age, per EPSDT, "Medically Necessary" shall be as defined in Section 2.1.74.1 (Definitions).

4.8.4 Notices of Coverage Determinations

4.8.4.1 The MCO shall provide the requesting Provider and the Member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

4.8.4.2 Urgent Determinations and Continued/Extended Services

4.8.4.2.1 The MCO shall make Utilization Management decisions in a timely manner. The following minimum standards shall apply:

4.8.4.2.1.1. Urgent Determinations: Determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for service for ninety-eight percent (98%) of requests, unless the Member or Member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.8.4.2.1.2. In the case of such failure, the MCO shall notify the Member or Member's representative within twenty-four (24) hours of receipt of the request

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and shall advise the Member or Member's representative of the specific information necessary to make a determination.

4.8.4.2.1.3. The Member or Member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information.

4.8.4.2.1.4. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the MCO's receipt of the specified additional information; or the end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.2.1.5. Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

4.8.4.3 All Other Determinations

4.8.4.3.1 The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed fourteen (14) calendar days for ninety-five percent (95%) of requests after the receipt of a request.

4.8.4.3.2 An extension of up to fourteen (14) calendar days is permissible for non-diagnostic radiology determinations if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

4.8.4.3.3 If an extension is necessary due to a failure of the Member or Member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the Member or Member's representative shall be given at least forty-five (45)

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calendar days from receipt of the notice within which to provide the specified information.

4.8.4.3.4 Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of:

4.8.4.3.4.1. The MCO's receipt of the specified additional information; or

4.8.4.3.4.2. The end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.3.4.3. When the MCO extends the timeframe, the MCO shall give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

4.8.4.3.5 The determination of a post service authorization shall be made within thirty (30) calendar days of the date of filing. In the event the Member fails to provide sufficient information to determine the request, the MCO shall notify the Member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the Member shall be given at least forty-five (45) calendar days to provide the required information.

4.8.4.3.6 The thirty (30) calendar day period for determination shall be tolled until such time as the Member submits the required information.

4.8.4.3.7 Whenever there is an adverse determination, the MCO shall notify the ordering Provider and the Member. For an adverse standard authorization decision, the MCO shall provide written notification within three (3) calendar days of the decision.

4.8.4.3.8 The MCO shall provide Utilization Management data to include but not be limited to timely processing, results, and frequency of service authorizations in accordance with Exhibit O.

4.8.5 Advance Directives

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4.8.5.1 The MCO shall adhere to all State and federal laws pertaining to Advance Directives including, but not limited to, RSA 137-J:21.

4.8.5.2 The MCO shall maintain written policies and procedures that meet requirements for Advance Directives in Subpart I of 42 CFR 489.

4.8.5.3 The MCO shall adhere to the definition of Advance Directives as defined in 42 CFR 489.100.

4.8.5.4 The MCO shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a)]

4.8.5.5 The MCO shall educate staff concerning policies and procedures on Advance Directives. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)]

4.8.5.6 The MCO shall not condition the provision of care or otherwise discriminate against a Member or potential Member based on whether or not the Member has executed an Advance Directive. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3)]

4.8.5.7 The MCO shall provide information in the Member Handbook with respect to how to exercise an Advance Directive, as described in Section 4.4.1.4 (Member Handbook). [42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j)]

4.8.5.8 The MCO shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. [42 CFR 438.3(j)(4)]

4.9 Member Education and Incentives

4.9.1 General Provisions

4.9.1.1 The MCO shall develop and implement evidenced-based wellness and prevention programs for its Members. The MCO shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by DHHS, including the National Diabetes Prevention Program. The MCO shall

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also participate in other public health initiatives at the direction of DHHS.

4.9.1.2 The MCO shall provide Members with general health information and provide services to help Members make informed decisions about their health care needs. The MCO shall encourage Members to take an active role in shared decision-making.

4.9.1.3 The MCO shall promote personal responsibility through the use of incentives and care management. The MCO shall reward Members for activities and behaviors that promote good health, health literacy and Continuity of Care. DHHS shall review and approve all reward activities proposed by the MCO prior to their implementation.

4.9.2 Member Health Education

4.9.2.1 The MCO shall develop and initiate a Member health education program that supports the overall wellness, prevention, and Care Management programs, with the goal of empowering patients to actively participate in their health care.

4.9.2.2 The MCO shall actively engage Members in both wellness program development and in program participation and shall provide additional or alternative outreach to Members who are difficult to engage or who utilize EDs inappropriately.

4.9.3 Member Cost Transparency

4.9.3.1 The MCO shall publish on its website and incorporate in its Care Coordination programs cost transparency information related to the relative cost of Participating Providers for MCO-selected services and procedures, with clear indication of which setting and/or Participating Provider is most cost-effective, referred to as "Preferred Providers."

4.9.3.2 The cost transparency information published by the MCO shall be related to select, non-emergent services, designed to permit Members to select between Participating Providers of equal quality, including the appropriate setting of care as assessed by the MCO. The services for which cost transparency data is provided may include, for example, services conducted in an outpatient hospital and/or ambulatory surgery center. The MCO should also include information regarding the appropriate use of EDs relative to low-acuity, non-emergent visits.

4.9.3.3 The information included on the MCO's website shall be accessible to all Members and also be designed for use specifically

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by Members that participate in the MCO's Reference-Based Pricing Incentive Program, as described in Section 4.9.4 (Member Incentive Programs) below.

4.9.4 Member Incentive Programs

4.9.4.1 The MCO shall develop at least one (1) Member Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as further described within this Section 4.9.4 (Member Incentive Programs) of the Agreement. The MCO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives of the MCOs and Providers described in Section 4.14 (Alternative Payment Models) of this Agreement as appropriate.

4.9.4.2 For all Member Incentive Programs developed, the MCO shall provide to participating Members that meet the criteria of the MCO-designed program cash or other incentives that:

4.9.4.2.1 May include incentives such as gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used for health-related purchases, gym memberships; and

4.9.4.2.2 Do not, in a given fiscal year for any one (1) Member, exceed a total monetary value of two hundred and fifty dollars (\$250.00).

4.9.4.3 The MCO shall submit to DHHS for review and approval all Member Incentive Program plan proposals prior to implementation

4.9.4.4 Within the plan proposal, the MCO shall include adequate assurances, as assessed by DHHS, that:

4.9.4.4.1 The program meets the requirements of 1112(a)(5) of the Social Security Act; and

4.9.4.4.2 The program meets the criteria determined by DHHS as described in Section 4.9.4.6 (Healthy Behavior Incentive Programs) and Section 4.9.4.7 (Reference-Based Pricing Incentive Programs) below.

4.9.4.5 The MCO shall report to DHHS, at least annually, the results of any Member Incentive Programs in effect in the prior twelve (12) months, including the following metrics and those indicated by DHHS, in accordance with Exhibit O:

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- 4.9.4.5.1 The number of Members in the program's target population, as determined by the MCO;
 - 4.9.4.5.2 The number of Members that received any incentive payments, and the number that received the maximum amount as a result of participation in the program;
 - 4.9.4.5.3 The total value of the incentive payments;
 - 4.9.4.5.4 An analysis of the statistically relevant results of the program; and
 - 4.9.4.5.5 Identification of goals and objectives for the next year informed by the data.
- 4.9.4.6 Healthy Behavior Incentive Programs**
- 4.9.4.6.1 The MCO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:
 - 4.9.4.6.1.1. Incorporate incentives for Members who complete a Health Risk Assessment Screening, in compliance with Section 4.10.2 of this Agreement (Health Risk Assessment Screening);
 - 4.9.4.6.1.2. Increase the timeliness of prenatal care, particularly for Members at risk of having a child with NAS;
 - 4.9.4.6.1.3. Address obesity;
 - 4.9.4.6.1.4. Prevent diabetes;
 - 4.9.4.6.1.5. Support smoking cessation;
 - 4.9.4.6.1.6. Increase lead screening rates in one- and two-year old Members; and/or
 - 4.9.4.6.1.7. Other similar types of healthy behavior incentive programs in consultation with the Division of Public Health within DHHS and in alignment with the DHHS Quality Strategy and the MCO's QAPI, as described in Section 4.9.3 (Member Cost Transparency).
- 4.9.4.7 Reference-Based Pricing Incentive Programs**
- 4.9.4.7.1 The MCO shall develop at least one (1) Reference-Based Pricing Member Incentive Program that encourages Members to use, when reasonable, Preferred Providers as assessed and indicated by the MCO and on its website in compliance with the

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Cost Transparency requirements included in Section 4.9.3 (Member Cost Transparency). The Reference-Based Pricing Member Incentive Program shall also include means for encouraging members' appropriate use of EDs and opportunities to direct Members to other settings for low acuity, non-emergent visits.

4.9.4.7.2 The MCO's Reference-Based Pricing Member Incentive Program shall be designed such that the Member may gain and lose incentives (e.g., through the development of a points system that is monitored throughout the year) based on the Member's adherence to the terms of the program throughout the course of the year.

4.9.5 Collaboration with New Hampshire Tobacco Cessation Programs

4.9.5.1 [Amendment #7:] The MCO shall promote and utilize the DHHS-approved tobacco treatment quitline, 1-800-QUITNOW (1-800-784-8669) ~~cessation quitline and tobacco cessation program~~ to provide:

4.9.5.1.1 Intensive tobacco cessation treatment through a DHHS-approved tobacco cessation quitline;

4.9.5.1.2 Individual tobacco cessation coaching/counseling in conjunction with tobacco cessation medication;

4.9.5.1.3 The following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by DHHS; and

4.9.5.1.4 Combination therapy, when available through quitline, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release.

4.9.5.2 The MCO shall provide tobacco cessation treatment to include, at a minimum:

4.9.5.2.1 Tobacco cessation coaching/counseling in addition to the quitline;

4.9.5.2.2 In addition to the quitline, the following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by DHHS;

4.9.5.2.3 In addition to the quitline, Combination therapy, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy

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(gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release;

4.9.5.2.4 Rebateable FDA-approved non-nicotine prescription medications; and

4.9.5.2.5 Rebateable FDA-approved prescription inhalers and nasal sprays.

4.9.5.3 The MCO shall report on tobacco cessation activities in accordance with Exhibit O.

4.10 Care Coordination and Care Management

4.10.1 Care Coordination and Care Management General Requirements

4.10.1.1 The MCO shall be responsible for the management, coordination, and Continuity of Care for all Members, and shall develop and maintain policies and procedures to address this responsibility.

4.10.1.2 The MCO shall implement Care Coordination and Care Management procedures to ensure that each Member has an ongoing source of care appropriate to their needs. [42 CFR 438.208(b)]

4.10.1.3 The MCO shall provide the services described in this Section 4.10 (Care Coordination and Care Management) for all Members who need Care Coordination and Case Management services regardless of their acuity level.

4.10.1.4 [Amendment #2:] The MCO shall either provide these services directly or shall subcontract with Local Care Management Networks—entities as described in Section 4.10.8 (Local Care Management) to perform Care Coordination and Care Management functions.

4.10.1.5 [Amendment #2:] Care Coordination means the interaction with established local community-based Providers of care including Local Care Management Networks—entities to address the physical, mental and psychosocial needs of the Member.

4.10.1.6 Care Management means direct contact with a Member focused on the provision of various aspects of the Member's physical, mental, Substance Use Disorder status and needed social supports that shall enable the Member in achieving the best health outcomes.

4.10.1.7 The MCO shall implement Care Coordination and Care Management in order to achieve the following goals:

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- 4.10.1.7.1 Improve care of Members;
 - 4.10.1.7.2 Improve health outcomes;
 - 4.10.1.7.3 Reduce inpatient hospitalizations including readmissions;
 - 4.10.1.7.4 Improve Continuity of Care;
 - 4.10.1.7.5 Improve transition planning;
 - 4.10.1.7.6 Improve medication management;
 - 4.10.1.7.7 Reduce utilization of unnecessary Emergency Services;
 - 4.10.1.7.8 Reduce unmet resource needs (related to social determinants of health);
 - 4.10.1.7.9 Decrease total costs of care; and
 - 4.10.1.7.10 Increase Member satisfaction with their health care experience.
- 4.10.1.8 The MCO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including PCPs, specialists, behavioral health Providers, and social service resources; the process shall include, but not be limited to, the designation of a Care Manager who shall be responsible for leading the coordination of care.
- 4.10.1.9 The MCO shall implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives from any other MCO. [42 CFR 438.208(b)(2)(ii)]
- 4.10.1.10 The MCO shall also implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives in FFS Medicaid, including dental services for children under the age of twenty-one (21). [42 CFR 438.208(b)(2)(iii)]
- 4.10.1.11 [Amendment #9:] The MCO shall provide care coordination support for Members who require services not covered by this Agreement as they may receive services through other appropriate Medicaid, commercial, or government health insurance programs. In such cases, the MCO's responsibility shall include coordination and referrals in compliance with 42 CFR 438.208(b)(2)(iii)-(iv).

4.10.2 Health Risk Assessment Screening

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4.10.2.1 The Health Risk Assessment Screening process shall identify the need for Care Coordination and Care Management services and the need for clinical and non-clinical services including referrals to specialists and community resources.

4.10.2.2 The MCO shall conduct a Health Risk Assessment Screening of all existing and newly enrolled Members within ninety (90) calendar days of the effective date of MCO enrollment to identify Members who may have unmet health care needs and/or Special Health Care Needs [42 CFR 438.208(c)(1)].

4.10.2.3 The MCO is not required to conduct a Health Risk Assessment Screening of Members residing in a nursing facility more than one hundred (100) consecutive calendar days.

4.10.2.4 The Health Risk Assessment shall be the same for each MCO. The agreed upon screening tool developed jointly by the MCOs shall be submitted to DHHS for review and approval, as part of the Readiness Review process, and annually thereafter.

4.10.2.5 The Health Risk Assessment Screening may be conducted by telephone, in person, or through completion of the form in writing by the Member. The MCO shall make at least three (3) reasonable attempts to contact a Member at the phone number most recently reported by the Member. [42 CFR 438.208(b)(3)]

4.10.2.6 Documentation of the three (3) attempts shall be included in the MCO electronic Care Management record. Reasonable attempts shall occur on not less than three (3) different calendar days, at different hours of the day including day and evening hours and after business hours. If after the three (3) attempts are unsuccessful, the MCO shall send a letter to the Member's last reported residential address with the Health Risk Assessment form for completion.

4.10.2.7 [Amendment #8:] [Amendment #2:] The MCO may also Subcontract with a Designated Local Care Management Network Entity, community-based agency or a primary care practice who shall engage the Member to complete the Health Risk Assessment screening either telephonically or in-person either in an agency office/clinic setting, during a scheduled home visit or medical appointment.

4.10.2.8 All completed Health Risk Assessments shall be shared with the Member's assigned PCP for inclusion in the Member's medical record and within seven (7) calendar days of completing the screening.

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4.10.2.9 The MCO shall report the number of Members who received a Health Risk Assessment, in accordance with Exhibit O.

4.10.2.10 The MCO shall share with DHHS and/or other MCOs the results of any identification and assessment of that Member's needs to prevent duplication of activities. [42 CFR 438.208(b)(4)]

4.10.2.11 The MCO shall report to DHHS its performance against Health Risk Assessment requirements, as described in Exhibit O.

4.10.2.12 ~~[Amendment #8:] [Amendment #5:] The MCO shall ensure Member Health Risk Assessment completion for Members shall be completed for at least twenty-five percent (25%) fifty percent (50%) of the plan's total required Members to be considered eligible for a performance-based award described in the Performance-Based Auto-Assignment Guidance, or the MCO shall provide to DHHS for review and approval additional documentation that describes the MCO's reasoning for failure to successfully complete Health Risk Assessments for fifty percent (50%) of Members. The MCO's reasoning shall be considered by DHHS prior to imposing Liquidated Damages, as described in Section 5.5.2 of this Agreement.~~

4.10.2.13 The evidence-based Health Risk Assessment Screening tool shall identify, at minimum, the following information about Members:

4.10.2.13.1 Demographics;

4.10.2.13.2 Chronic and/or acute conditions;

4.10.2.13.3 Chronic pain;

4.10.2.13.4 The unique needs of children with developmental delays, Special Health Care Needs or involved with the juvenile justice system and child protection agencies (i.e. DCYF);

4.10.2.13.5 Behavioral health needs, including depression or other Substance Use Disorders as described in sections, including but not limited to Section 4.11.1.16 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.11.5.4 (Comprehensive Assessment and Care Plans), and Section 4.11.6.6 (Provision of Substance Use Disorder Services);

4.10.2.13.6 The need for assistance with personal care such as dressing or bathing or home chores and grocery shopping;

4.10.2.13.7 Tobacco Cessation needs;

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4.10.2.13.8 Social determinants of health needs, including housing, childcare, food insecurity, transportation and/or other interpersonal risk factors such as safety concerns/caregiver stress; and

4.10.2.13.9 Other factors or conditions about which the MCO shall need to be aware to arrange available interventions for the Member.

4.10.2.14 Wellness Visits

4.10.2.14.1 For all Members, inclusive of Granite Advantage Members, the MCO shall support the Member to arrange a wellness visit with his or her PCP, either previously identified or selected by the Member from a list of available PCPs.

4.10.2.14.2 The wellness visit shall include appropriate assessments for the purpose of developing a health wellness and care plan:

4.10.2.14.2.1. Both physical and behavioral health, including screening for depression;

4.10.2.14.2.2. Mood, suicidality; and

4.10.2.14.2.3. Substance Use Disorder.

4.10.3 Priority Populations

4.10.3.1 The following populations shall be considered Priority Populations and are most likely to have Care Management needs:

4.10.3.1.1 Adults with Special Health Care Needs, meaning those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age.

4.10.3.1.1.1. This includes, but is not limited to Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis, or with chronic pain;

4.10.3.1.2 Children with Special Health Care Needs meaning those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age.

4.10.3.1.2.1. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with NAS; in high stress

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social environments/caregiver stress; receiving Family Centered Early Supports and Services, or participating in Special Medical Services or Partners in Health Services with an SED, I/DD or Substance Use Disorder diagnosis;

4.10.3.1.3 Members receiving services under HCBS waivers;

4.10.3.1.4 Members identified as those with rising risk. The MCO shall establish criteria that define Members at rising risk for approval by DHHS as part of the Readiness Review process and reviewed and approved annually;

4.10.3.1.5 Individuals with high unmet resources needs meaning MCM Members who are homeless; experiencing domestic violence or perceived lack of personal safety; and/or demonstrate unmet resource needs as further described in Section 4.10.10 (Coordination and Integration with Social Services and Community Care);

4.10.3.1.5.1. Recently incarcerated;

4.10.3.1.5.2. Mothers of babies born with NAS;

4.10.3.1.5.3. Pregnant women with Substance Use Disorders;

4.10.3.1.5.4. IV Drug Users, including Members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use;

4.10.3.1.5.5. Members who have been in the ED for an overdose event in the last twelve (12) months;

4.10.3.1.5.6. Members who have a suicide attempt in the last twelve (12) months;

4.10.3.1.5.7. Members with an I/DD diagnosis; and/or

4.10.3.1.5.8. Other Priority Populations as determined by the MCO and/or by DHHS.

4.10.4 Risk Scoring and Stratification

4.10.4.1 The MCO shall use a Risk Scoring and Stratification methodology to identify Members who are part of a Priority Population or who are otherwise high risk/high need for Care Management and who should receive a Comprehensive Assessment.

4.10.4.2 The MCO shall provide protocols to DHHS for review and approval on how Members are stratified by severity and risk level,

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including details regarding the algorithm and data sources used to identify Members eligible for Care Management.

4.10.4.3 Such protocols shall be submitted as part of the Readiness Review process and annually thereafter.

4.10.4.4 Risk Scoring and Stratification of Members should be conducted at MCO program roll out and monthly thereafter.

4.10.4.5 The MCO's Risk Scoring and Stratification methodology shall take into account, at a minimum, the following information:

4.10.4.5.1 Results of the health risk assessment screening;

4.10.4.5.2 Claims history and Encounter Data;

4.10.4.5.3 Pharmacy data;

4.10.4.5.4 Immunizations;

4.10.4.5.5 ADT of Members to and from inpatient facilities;

4.10.4.5.6 Provider referral;

4.10.4.5.7 Member self-referral;

4.10.4.5.8 Hospital stays of more than two (2) weeks;

4.10.4.5.9 Members without secure and stable housing post hospital discharge;

4.10.4.5.10 Three (3) or more ED visits within a single calendar quarter;

4.10.4.5.11 Discharge from inpatient Behavioral Health Services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center; and

4.10.4.5.12 Neonatal Intensive Care Unit discharges.

4.10.4.6 The MCO shall document and submit to DHHS for review and approval the details of its Risk Scoring and Stratification methodology as part of its Readiness Review and annually thereafter. This submission shall include:

4.10.4.6.1 Information and data to be utilized;

4.10.4.6.2 Description of the methodology;

4.10.4.6.3 Methodology and Criteria for identifying high risk/high need Members in addition to those who are in Priority Populations;

4.10.4.6.4 Number of risk strata;

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4.10.4.6.5 Criteria for each risk stratum, including but not limited to high risk/high need members in need of Care Management; and

4.10.4.6.6 Approximate expected population in each stratum.

4.10.4.7 The MCO shall submit any change in its risk stratification methodologies, to include any additions or deletions to that methodology, for DHHS review ninety (90) calendar days prior to the change being implemented.

4.10.4.8 The MCO shall report annually the number and percentage of Members who are identified in each of the risk strata in accordance with Exhibit O.

4.10.5 Comprehensive Assessment for High-Risk and High-Need Members

4.10.5.1 The MCO and its Subcontractors shall implement mechanisms to conduct a Comprehensive Assessment for each Medicaid Member in order to identify whether they have Special Health Care Needs and any on-going special conditions that require a course of treatment or regular care monitoring. [42 CFR 438.208(c)(2)]

4.10.5.2 The MCO shall identify Members who may require a Comprehensive Assessment for Care Management through multiple sources to include but not be limited to:

4.10.5.2.1 Health risk assessment screenings;

4.10.5.2.2 Risk Scoring and Stratification;

4.10.5.2.3 Claims/encounter analysis;

4.10.5.2.4 Provider referrals;

4.10.5.2.5 Member/caregiver self-referral; and

4.10.5.2.6 Referrals from community based medical, mental health, Substance Use Disorder Providers, or social service entities.

4.10.5.3 The Comprehensive Assessment shall identify a Member's health condition that requires a course of treatment that is either episodic, which is limited in duration or significance to a particular medical episode,

or requires ongoing Care Management monitoring to ensure the Member is managing his or her medical and/or behavioral health care needs (including screening for depression, mood, suicidality, and Substance Use Disorder).

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4.10.5.4 The Comprehensive Assessment shall be a person-centered assessment of a Member's medical and behavioral care needs, functional status, accessibility needs, strengths and supports, health care goals and other characteristics that shall inform whether the Member should receive Care Management and shall inform the Member's ongoing care plan and treatment. The MCO shall incorporate into the Comprehensive Assessment information obtained as a result of Provider referral, the wellness visit and/or otherwise.

4.10.5.5 The MCO's Comprehensive Assessment tool shall be submitted for DHHS review and approval as part of the Readiness Review process and annually thereafter.

4.10.5.6 The MCO shall make best efforts to complete the Comprehensive Assessment within thirty (30) calendar days of identifying a Member as being part of one or more Priority Populations, identified through Risk Scoring and Stratification or having received a referral for Care Management.

4.10.5.7 The MCO shall not withhold any Medically Necessary Services including EPSDT services per Section 4.1.8 (Early and Periodic Screening, Diagnostic, and Treatment) for Members while awaiting the completion of the Comprehensive Assessment but may conduct utilization review for any services requiring Prior Authorization.

4.10.5.8 The MCO shall conduct the Comprehensive Assessment in a location of the Member's choosing and shall endeavor to conduct the Comprehensive Assessment in-person for populations where the quality of information may be compromised if provided telephonically (e.g., for Members whose physical or behavioral health needs may impede the ability to provide comprehensive information by telephone), including others in the person's life in the assessment process such as family members, paid and natural supports as agreed upon and appropriate to the Member/Member's parents to the maximum extent practicable.

4.10.5.9 Additionally, participation in the Comprehensive Assessment shall be extended to the Member's local community care team or Case Management staff, including but not limited to Area Agencies, CFI waiver, CMH Programs and Special Medical Services 1915(i) Care Management Entities/case managers as practicable.

4.10.5.10 The MCO shall develop and implement a Comprehensive Assessment tailored to Members that include, at a minimum, the following domains/content:

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- 4.10.5.10.1 Members' immediate care needs;
 - 4.10.5.10.2 Demographics;
 - 4.10.5.10.3 Education;
 - 4.10.5.10.4 Housing;
 - 4.10.5.10.5 Employment and entitlements;
 - 4.10.5.10.6 Legal involvement;
 - 4.10.5.10.7 Risk assessment, including suicide risk;
 - 4.10.5.10.8 Other State or local community and family support services currently used;
 - 4.10.5.10.9 Medical and other health conditions;
 - 4.10.5.10.10 Physical, I/DDs;
 - 4.10.5.10.11 Functional status (activities of daily living (ADL)/instrumental activities of daily living (IADL)) including cognitive functioning;
 - 4.10.5.10.12 Medications;
 - 4.10.5.10.13 Available informal, caregiver, or social supports, including peer supports;
 - 4.10.5.10.14 Current and past mental health and substance use status and/or disorders;
 - 4.10.5.10.15 Social determinants of health needs; and
 - 4.10.5.10.16 Exposure to adverse childhood experiences or other trauma (e.g., parents with mental health or Substance Use Disorders that affect their ability to protect the safety of the child, child abuse or neglect).
- 4.10.5.11 The MCO shall provide to DHHS a copy of the Comprehensive Assessment Form and all policies and procedures relating to conducting the Comprehensive Assessment for DHHS review as part of the Readiness Review process and annually thereafter.
- 4.10.5.12 The MCO shall conduct a re-assessment of the Comprehensive Assessment for a Member receiving ongoing care management:
- 4.10.5.12.1 At least annually;
 - 4.10.5.12.2 When the Member's circumstances or needs change significantly;

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4.10.5.12.3 At the Member's request; and/or

4.10.5.12.4 Upon DHHS's request.

4.10.5.13 The MCO shall share the results of the Comprehensive Assessment in writing with the Member's local community based care team within fourteen (14) calendar days to inform care planning and treatment planning, with Member consent to the extent required by State and federal law.

4.10.5.14 The MCO shall report to DHHS the following in accordance with Exhibit O:

4.10.5.14.1 Assessments conducted as a percentage (%) of total Members and by Priority Population category;

4.10.5.14.2 Assessments completed by a Subcontractor entity, such as but not limited to IDNs, CMH Programs, Special Medical Services, HCBS case managers, and Area Agencies;

4.10.5.14.3 Timeliness of assessments;

4.10.5.14.4 Timeliness of dissemination of assessment results to PCPs, specialists, behavioral health Providers and other members of the local community based care team; and

4.10.5.14.5 Quarterly report of unmet resource needs, aggregated by county, based on the care screening and Comprehensive Assessment tool to include number of Members reporting in accordance with Exhibit O.

4.10.6 Care Management for High Risk and High Need Members

4.10.6.1 The MCO shall provide Care Management for Members identified as "high-risk"/"high-need" through the Comprehensive Assessment. Every high-risk/high-need Member identified as needing Care Management shall be assigned a designated Care Manager.

4.10.6.2 [Amendment #5:] Beginning January 1, 2021, Care Management for high-risk/high-need Members shall be conducted for at least three percent (3%) of the total Members. [Amendment #5:] For the period January 1, 2021 through June 30, 2021, Care Management for high-risk/high-need Members shall be conducted for at least three percent (3%) of the total Members by March 1, 2021.

4.10.6.2.1 [Amendment #6:] Beginning March 1, 2021, Care Management for shall be conducted for at least three percent (3%) of the total membership.

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~~[Amendment #1:] Care Management for high-risk/high-need Members shall be conducted for at least 15 percent (15%) of the total Members by March 1, 2020, or the MCO shall provide to DHHS documentation of how fewer Members were determined not to meet the MCO's Risk Stratification Criteria for being high-risk/high-need members in need of Care Management.~~

~~[Base Contract:] Care Management for high-risk/high-need Members shall be conducted for at least 15 percent (15%) of the total Members by January 1, 2020, or the MCO shall provide to DHHS documentation of how fewer Members were determined not to meet the MCO's Risk Stratification Criteria for being high-risk/high-need members in need of Care Management.~~

4.10.6.3 Members selected for Care Management shall be informed of:

4.10.6.3.1 The nature of the Care Management engagement relationship;

4.10.6.3.2 Circumstances under which information shall be disclosed to third parties, consistent with State and federal law;

4.10.6.3.3 The availability of a grievance and appeals process;

4.10.6.3.4 The rationale for implementing Care Management services; and

4.10.6.3.5 The processes for opting out of and terminating Care Management services.

4.10.6.4 The MCO's Care Management responsibilities shall include, at a minimum:

4.10.6.4.1 Coordination of physical, mental health, Substance Use Disorder and social services;

4.10.6.4.2 Quarterly medication reconciliation;

4.10.6.4.3 Monthly telephonic contact with the Member;

4.10.6.4.4 Monthly communication with the care team either in writing or telephonically for coordination and updating of the care plan for dissemination to care team participants;

4.10.6.4.5 Referral follow-up monthly;

4.10.6.4.6 Peer support;

4.10.6.4.7 Support for unmet resource needs;

4.10.6.4.8 Training on disease self-management, as relevant; and

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4.10.6.4.9 Transitional Care Management as defined in Section 4.10.9 (Transitional Care Management).

4.10.6.5 The MCO shall convene a local community based care team for each Member receiving Care Management where relevant, dependent on a Member's needs including, but not limited to, the Member, caretaker(s), PCP, behavioral health Provider(s), specialist(s), HCBS case managers, school personnel as needed, nutritionist(s), and/or pharmacist(s).

4.10.6.6 The care team shall be chosen by the Member whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships.

4.10.6.7 The MCO shall identify what information is to be shared and how that information is communicated among all of the care team participants concerned with a Member's care to achieve safer and more effective health care including how the Care Coordination program interfaces with the Member's PCP and/or specialist Providers and existing community resources and supports.

4.10.6.8 The MCO shall develop a care plan, within 30 calendar days of the completed Comprehensive Assessment, for each high-risk/high need Member identified through a Comprehensive Assessment who is in need of a course of treatment or regular Care Management monitoring. [42 CFR 438.208(c)(3)]

4.10.6.9 The MCO's care plan shall be regularly updated and incorporate input from the local community based care team participants and the Member. The care plan shall be comprehensively updated:

4.10.6.9.1 At least quarterly;

4.10.6.9.2 When a Member's circumstances or needs change significantly;

4.10.6.9.3 At the Member's request;

4.10.6.9.4 When a re-assessment occurs; and

4.10.6.9.5 Upon DHHS's request.

4.10.6.10 The care plan format shall be submitted to DHHS for review as part of the Readiness Review process and annually thereafter.

4.10.6.11 The MCO shall track the Member's progress through routine care team conferences, the frequency to be determined by the MCO based on the Member's level of need.

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4.10.6.12 The MCO shall develop policies and procedures that describe when Members should be discharged from the Care Management program, should the care team determine that the Member no longer requires a course of treatment which was episodic or no longer needs ongoing care monitoring.

4.10.6.13 Policies and procedures for discharge shall include a Member notification process.

4.10.6.14 For high-risk/high-needs Members who have been determined, through a Comprehensive Assessment, to need a course of treatment or regular care monitoring, the MCO shall ensure there is a mechanism in place to permit such Members to directly access a specialist as appropriate for the Member's condition and identified needs. [42 CFR 438.208(c)(4)]

4.10.6.15 The MCO shall ensure that each Provider furnishing services to Members maintains and shares a Member health record in accordance with professional standards. [42 CFR 438.208(b)(5)]

4.10.6.16 The MCO shall use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Member in accordance with confidentiality requirements in 45 CFR 160 and 164, this Agreement, and all other applicable laws and regulations. [42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164]

4.10.6.17 The MCO shall develop and implement a strategy to address how the Interoperability Standards Advisory standards, from the Office of the National Coordinator for Health Information Technology, informs the MCO system development and interoperability.

4.10.7 Care Managers

4.10.7.1 The MCO shall formally designate a Care Manager that is primarily responsible for coordinating services accessed by the Member.

4.10.7.2 The MCO shall provide to Members information on how to contact their designated Care Manager. [42 CFR 438.208(b)(1)]

4.10.7.3 [Amendment #2:] Care Managers, whether hired by the MCO or subcontracted through a Designated Local Care Management Network—Entity, shall have the qualifications and competency in the following areas:

4.10.7.3.1 All aspects of person-centered needs assessments and care planning;

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- 4.10.7.3.2 Motivational interviewing and self-management;
- 4.10.7.3.3 Trauma-informed care;
- 4.10.7.3.4 Cultural and linguistic competency;
- 4.10.7.3.5 Understanding and addressing unmet resource needs including expertise in identifying, accessing and utilizing available social support and resources in the Member's community; and
- 4.10.7.3.6 Adverse childhood experiences and trauma.

4.10.7.4 Care Managers shall be trained in the following:

- 4.10.7.4.1 Disease self-management;
- 4.10.7.4.2 Person-centered needs assessment and care planning including coordination of care needs;
- 4.10.7.4.3 Integrated and coordinated physical and behavioral health;
- 4.10.7.4.4 Behavioral health crisis response (for Care Managers with assigned Members with behavioral health needs);
- 4.10.7.4.5 Cultural and linguistic competency;
- 4.10.7.4.6 Family support; and
- 4.10.7.4.7 Understanding and addressing unmet resource needs, including expertise in identifying and utilizing available social supports and resources in the Member's community.

4.10.7.5 Care Managers shall remain conflict-free which shall be defined as not being related by blood or marriage to a Member, financially responsible for a Member, or with any legal power to make financial or health related decisions for a Member.

4.10.8 Local Care Management

4.10.8.1 Local Care Management shall mean that the MCO shall provide real-time, high-touch, in-person Care Management and consistent follow up with Providers and Members to assure that selected Members are making progress with their care plans.

4.10.8.1.1 [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] As described in this Section 4.10.8, Local Care Management is optional for the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ 2024.

4.10.8.1.1.1. [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] For the period July

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1, 2021 through August 31, 2024 June 30-December 31, 2023, the term "Local Care Management" shall also mean "Care Management" in this Section 4.10.8.

4.10.8.1.2 [Amendment #9] [Amendment #7] [Amendment #6:] Intentionally left blank. The MCO shall be eligible for credit to the withhold calculation described in the MCM Withhold and Incentive Program guidance when the MCO opts to participate in a Department approved Local Care Management Pilot during the period described in Section 4.10.8.1.1, and meets obligations of the Pilot as described in separate guidance. [Amendment #5:] The MCO shall be eligible for a one-half percent (.5%) credit to the withhold calculation described in the MCM Withhold and Incentive Program guidance when the MCO opts to participate in a Department approved Local Care Management Pilot during the period described in Section 4.10.8.1.1. Eligibility for the withhold credit requires the MCO's earnest participation and effort to successfully develop the Pilot as determined solely by DHHS and outlined in the MCM Withhold and Incentive Guidance.

4.10.8.1.2.1. [Amendment #6:] For the Pilot timeframe January 1, 2021 through June 30, 2021, the MCO shall be eligible for one-half (.5%) percent credit to the withhold calculation as described in the MCM Withhold and Incentive Guidance.

4.10.8.1.2.2. [Amendment #7:] For the Pilot timeframe July 1, 2021 through December 31, 2021, the MCO shall be eligible for additional one-quarter (.25%) percent credits to the SFY 2021 withhold calculation for successful implementation of each of the four (4) subsequent phases of the Pilot up to a one percent (1%) withhold credit as determined at DHHS's sole discretion. [Amendment #6:] For the Pilot timeframe beginning July 1, 2021, the MCO shall be eligible for additional one-quarter (.25%) percent credits to the withhold calculation for successful implementation of each of the four (4) subsequent phases of the Pilot up to a one percent (1%) withhold credit as described in the MCM Withhold and Incentive Guidance to be developed over time.

4.10.8.1.2.3. [Amendment #6:] Eligibility for the withhold credit requires the MCO's earnest participation and effort to successfully develop the Pilot as determined solely by DHHS and outlined in the MCM Withhold and Incentive Guidance.

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4.10.8.1.3 ~~[Amendment #8:] [Amendment #7:] For the Pilot timeframe January 1, 2022 through June 30-December 31, 2022, the MCO shall be eligible for a SFY 2022 withhold calculation credit up to one-half percent (.5%) as described in the MCM Withhold and Incentive Guidance.~~

4.10.8.1.4 ~~[Amendment #9:] [Amendment #8] Intentionally left blank. The MCO shall be eligible for a SFY 2023 withhold capitation credit up to one-half percent (.5%) based on Members who have completed their determinations between July 1, 2022 through December 31, 2022 as described in the MCM Withhold and Incentive Guidance.~~

4.10.8.2 The MCO shall design an effective Local Care Management structure for fifty percent (50%) of high-risk or high-need Members, including those who are medically and socially complex or high utilizers.

4.10.8.3 ~~[Amendment #5:]~~ The MCO shall ensure that the fifty percent (50%) requirement is met by ensuring access to Local Care Management in all regions of New Hampshire by ~~January 1, 2024~~; the MCO shall be considered out of compliance should any one (1) region have less than twenty five percent (25%) of high-risk or high-need Members receiving Local Care Management, unless the MCO receives DHHS approval as part of the MCO's Local Care Management Plan (further described in this Section 4.10.8).

4.10.8.4 The MCO is encouraged to leverage Local Care Management by contracting with designated community-based agencies or Care Management entities, inclusive of IDNs that meet requirements, that shall assume responsibility for performing Care Coordination, Transitional Care Management, and/or Care Management functions for high risk and/or high-need Members.

4.10.8.4.1 ~~[Amendment #2:]~~ After good faith negotiations with a Local Care Management Network Agency should the MCO be unable to contract with the Local Care Management Network Agency for Care Coordination, Transitional Care Management, and/or Care management functions for high-risk/high-need Members, and continue to be unable to contract with any Local Care Management Network Agency after subsequent good faith negotiations with the assistance of DHHS, the MCO may submit to DHHS for a request for an exception to the requirement for compliance with the 50% Local Care Management standard. DHHS may approve or deny the request in its sole discretion.

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4.10.8.5 [Amendment #2:] The MCO, or its Designated Local Care Management ~~Network-Entity~~, shall designate Care Managers who shall provide in-person Care Management for Members either in the community setting, provider outpatient setting, hospital, or ED.

4.10.8.6 [Amendment #2:] The MCO shall ensure there is a clear delineation of roles and responsibilities between the MCO and Designated Local Care Management ~~Networks-Entities~~ that are responsible for Care Management in order to ensure no gaps or duplication in services.

4.10.8.7 The MCO or its designated Local Care Managers shall be embedded in one (1) outpatient service site, float between multiple outpatient sites, provide transition of care services from the hospital or ED setting, and provide home based Care Management.

4.10.8.8 [Amendment #2:] Designated Local Care Management ~~Networks-Entities~~ shall include:

4.10.8.8.1 [Amendment #2:] IDNs that have been certified as Local Care Management ~~Networks-Entities~~ by DHHS;

4.10.8.8.2 Health Homes, if DHHS elects to implement Health Homes under Medicaid State Plan Amendment authority;

4.10.8.8.3 Designated community-based agencies or Care Management entities, inclusive of IDNs that meet requirements and DHHS designated regional substance use disorder hubs or spokes, that shall assume responsibility for performing Care Coordination, Transitional Care Management, and/or Care Management functions for high risk and/or high-need Members;

4.10.8.8.4 Other contracted entities capable of performing Local Care Management for a designated cohort of Members, as identified by the MCO as part of its Local Care Management Plan (further described in this Section 4.10.8) and approved by DHHS;

4.10.8.8.5 [Amendment #2:] For the delegation to community-based agencies or Care Management entities ~~designated local care management entities~~ not certified by DHHS for medical utilization review services, the MCO shall seek, where required, licensing in accordance with any State or federal law, including but not limited to RSA 420-E, or additional NCQA accreditation.

4.10.8.9 DHHS shall evaluate whether IDNs are able to provide effective Local Care Management services to selected populations; if and when one (1) or more IDNs are certified, the MCO is required to

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directly contract with the certified IDN(s) for the delivery of Local Care Management services.

4.10.8.10 For any IDN that is not certified by DHHS, the MCO is not required to directly contract with the uncertified IDN for the delivery of Local Care Management services (either because the individual IDN was not certified and/or DHHS has not yet instituted its certification process).

4.10.8.10.1 In this instance the MCO shall enter into a memorandum of understanding with the non-certified IDN(s).

4.10.8.10.2 The memorandum of understanding shall identify roles and responsibilities with respect to Members served by the MCO and the IDN(s), and provide for the timely exchange of data between the MCO and the IDN(s) on such Members.

4.10.8.11 The MCO shall also work with IDNs to leverage regional access point services. The MCO is required to contract with and enter into a payment arrangement with qualified IDNs, providing for reimbursement on terms specified by DHHS in guidance unless otherwise approved by DHHS.

4.10.8.12 [Amendment #2:] Any Care Coordination and Care Management requirements that apply to the MCO shall also apply to the MCOs' Designated Local Care Management Networks-Entities.

4.10.8.13 [Amendment #5:] The MCO shall amend its Care Management Plan to describe its Local Care Management Plan ~~by September 1, 2020, as prescribed by DHHS, and annually thereafter in accordance with Exhibit O for prior approval by DHHS.~~ [Amendment #2:] ~~The MCO shall submit to DHHS its Local Care Management Plan in accordance with Exhibit O for prior approval by DHHS as part of the Readiness Review and annually thereafter.~~

4.10.8.14 [Amendment #2:] The Plan shall include the structure of the Local Care Management to be provided, the percentage (%) of high-risk/high-need Members who shall receive Local Care Management, the list of Designated Local Care Management Networks-Entities that shall conduct the Local Care Management, and a description of the geography and Priority Populations the Designated Local Care Management Networks-Entities shall serve.

4.10.8.15 The MCO shall report against their Local Care Management Plans in accordance with Exhibit O, including:

4.10.8.15.1 Volume of Care Management outreach attempts;

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4.10.8.15.2 Number of Members receiving Local Care Management by intensity of engagement;

4.10.8.15.3 Duration of sustained Local Care Management activities;

4.10.8.15.4 Number and percent (%) of Members receiving face-to-face Care Management; and

4.10.8.15.5 Type of staff conducting face-to-face Local Care Management

4.10.8.16 [Amendment #2:] Data Sharing with Local Care Management Networks—Entities

4.10.8.16.1 [Amendment #2:] Consistent with all applicable State and federal laws and regulations, and utilizing all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information and to facilitate the provision of services and Care Management as intended by this Agreement, the MCO shall provide identifiable Member-level data on a monthly basis to Local Care Management Networks—Entities, all community-based agencies or Care Management entities with which the MCO otherwise subcontracts for purposes of providing Care Management and care coordination to MCM Members, and IDNs regarding:

4.10.8.16.1.1. Each Member's diagnosis(es);

4.10.8.16.1.2. Utilization of services;

4.10.8.16.1.3. Total cost of care

4.10.8.16.1.4. Point of access to service.

4.10.8.16.2 [Amendment #8:] The MCO shall, as described in Section 4.10.9 (Transitional Care Management), demonstrate that it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real time or designated receiving facility in real time or near real time.

4.10.8.16.3 [Amendment #2:] The MCO shall ensure that ADT data from applicable hospitals be made available to Primary Care Providers, behavioral health Providers, Integrated Delivery Networks, Local Care Management Networks—Entities, community-based agencies, and all other Care Management entities within twelve (12) hours of the admission, discharge, or transfer.

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4.10.8.16.4 [Amendment #2:] The MCO shall, as directed by DHHS and demonstrated during the readiness period, collaborate with the IDNs to utilize the event notification and shared care plan system employed by IDNs as applicable for exchanging Member information necessary to provide Care Management and Care Coordination services to Members served by an IDN and, as applicable, other Local Care Management Networks-Entities.

4.10.9 Transitional Care Management

4.10.9.1 [Amendment #8:] The MCO shall be responsible for managing transitions of care for all Members moving from one (1) clinical setting to another, including step-up or step-down treatment programs for Members in need of continued mental health and Substance Use Disorder services, to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

4.10.9.2 The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

4.10.9.3 The MCO shall develop policies and procedures for DHHS review, as part of the Readiness Review process and annually thereafter, which describe how transitions of care between settings shall be effectively managed including data systems that trigger notification that a Member is in transition.

4.10.9.4 The MCO's transition of care policies shall be consistent with federal requirements that meet the State's transition of care requirements. [42 CFR 438.62(b)(1)-(2)]

4.10.9.5 The MCO shall have a documented process to, at a minimum:

4.10.9.5.1 Coordinate appropriate follow-up services from any inpatient or facility stay;

4.10.9.5.2 Support continuity of care for Members when they move from home to foster care placement; foster care to independent living; return from foster care placement to community; or change in legal status from foster care to adoption.

4.10.9.5.3 Schedule a face-to-face visit to complete a Comprehensive Assessment and update a Member's care plan when a Member is hospitalized;

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4.10.9.5.4 Evaluate Members for continued mental health and Substance Use Disorder services upon discharge from an inpatient psychiatric facility or residential treatment center as described in Section 4.11.5.18 (New Hampshire Hospital); and

4.10.9.5.5 Coordinate with inpatient discharge planners for Members referred for subacute treatment in a nursing facility.

4.10.9.6 The MCO shall have an established process to work with Providers (including hospitals regarding notice of admission and discharge) to ensure appropriate communication among Providers and between Providers and the MCO to ensure that Members receive appropriate follow-up care and are in the most integrated and cost-effective delivery setting appropriate for their needs.

4.10.9.7 The MCO shall implement a protocol to identify Members who use ED services inappropriately, analyze reasons why each Member did so and provide additional services to assist the Member to access appropriate levels of care including assistance with scheduling and attending follow-up care with PCPs and/or appropriate specialists to improve Continuity of Care, resolve Provider access issues, and establish a medical home.

4.10.9.8 The MCO shall demonstrate, at a minimum, that it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real time or near real time.

4.10.9.9 [Amendment #2:] The MCO shall ensure that ADT data from applicable hospitals be made available to Primary Care Providers, behavioral health Providers, Integrated Delivery Networks, Local Care Management ~~Networks~~ Entities, and all other Care Management Entities within twelve (12) hours of the admission, discharge, or transfer.

4.10.9.10 The MCO shall ensure that Transitional Care Management includes, at a minimum:

4.10.9.10.1 Care Management or other services to ensure the Member's care plan continues;

4.10.9.10.2 Facilitating clinical hand-offs;

4.10.9.10.3 Obtaining a copy of the discharge plan/summary prior to the day of discharge, if available, otherwise, as soon as it is available, and documenting that a follow-up outpatient visit is scheduled, ideally before discharge;

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4.10.9.10.4 Communicating with the Member's PCP about discharge plans and any changes to the care plan;

4.10.9.10.5 Conducting medication reconciliation within forty-eight (48) business hours of discharge;

4.10.9.10.6 Ensuring that a Care Manager is assigned to manage the transition;

4.10.9.10.7 Follow-up by the assigned Care Manager within forty-eight (48) business hours of discharge of the Member;

4.10.9.10.8 Determining when a follow up visit should be conducted in a Member's home

4.10.9.10.9 Supporting Members to keep outpatient appointments; and

4.10.9.10.10 A process to assist with supporting continuity of care for the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care who become enrolled in the plan, including prospective enrollment so that any care required prior to effective date of enrollment is covered.

4.10.9.11 The MCO shall assist with coordination between the children and adolescent service delivery system as these Members transition into the adult mental health service delivery system, through activities such as communicating treatment plans and exchange of information.

4.10.9.12 The MCO shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

4.10.9.12.1 The outpatient Provider shall be involved in the admissions process when possible; if the outpatient Provider is not involved, the outpatient Provider shall be notified promptly of the Member's hospital admission;

4.10.9.12.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan (i.e. an outpatient visit shall be scheduled before discharge to ensure access to proper Provider/medication follow-up; and an appropriate placement or housing site shall be secured prior to discharge);

4.10.9.12.3 The hospital's evaluation shall be performed prior to discharge to determine what, if any, mental health or Substance Use Disorder services are Medically Necessary. Once deemed Medically

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Necessary, the outpatient Provider shall be involved in the discharge planning, the evaluation shall include an assessment for any social services needs such as housing and other necessary supports the young adults need to assist in their stability in their community; and

4.10.9.12.4 A procedure to ensure Continuity of Care regarding medication shall be developed and implemented.

4.10.10 Coordination and Integration with Social Services and Community Care

4.10.10.1 The MCO shall implement procedures to coordinate services the MCO furnishes to Members with the services the Member receives from community and social service Providers. [42 CFR 438.208(b)(2)(iv)]

4.10.10.2 The MCO shall utilize 2-1-1 NH, which is New Hampshire's statewide, comprehensive, information and referral service. The MCO shall leverage and partner with 2-1-1 NH to ensure warm transfers and the ability to report on closed loop referrals.

4.10.10.3 The MCO's Care Management shall include help for Members in addressing unmet resource needs through strategies including, at a minimum:

4.10.10.3.1 How the MCO identifies available community support services and facilitates referrals to those entities for Members with identified needs;

4.10.10.3.2 Providing in-person assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications;

4.10.10.3.3 Having a housing specialist on staff or on contract who can assist Members who are homeless in securing housing; and

4.10.10.3.4 Providing access to medical-legal partnership for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance Providers.

4.10.10.4 In addressing unmet resource needs for Members, the MCO shall promote access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support. The MCO shall establish Care Management competencies, as outlined below:

4.10.10.4.1 Health Risk Assessment Screening, Claims Analysis, and/or Member or Provider Referral: the MCO ensure that a care needs screening, including social determinants of health questions, is conducted.

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4.10.10.4.2 Risk Scoring and Stratification by Member Level of Need: The MCO shall identify Priority Populations for further review and likely receipt of intensive Care Management services. With respect to social determinants, the MCO, at minimum, shall ensure that Priority Populations are inclusive of homeless Members, Members facing multiple barriers to food, housing and transportation.

4.10.10.4.3 High Risk/High-Need Members: The MCO shall ensure that a more in-depth assessment is conducted to confirm the need for Care Management services and begin to develop a care plan. As with the screening, the in-depth assessment shall include questions regarding social determinants of health.

4.10.10.4.4 The MCO shall provide/arrange for Care Management services that take into account social determinants of health. At minimum, these services shall include in-person assistance connecting with social services that can improve health, including a housing specialist familiar with options in the community.

4.10.10.5 For Members who do not require such intensive services, the MCO shall provide guidance/navigational coordination, which includes:

4.10.10.5.1 Ensuring that each Member has an ongoing source of care and health services appropriate for his or her needs;

4.10.10.5.2 Coordinating services provided by community and social support Providers;

4.10.10.5.3 Linking Members to community resources and social supports; and

4.10.10.5.4 Reporting on closed loop referrals or the overall effectiveness of the types of social determinant-related Care Coordination services, in accordance with Exhibit O.

4.10.10.6 The MCO shall develop relationships that actively link Members with other State, local, and community programs that may provide or assist with related health and social services to Members including, but not limited to:

4.10.10.6.1 Juvenile Justice and Adult Community Corrections;

4.10.10.6.2 Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

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4.10.10.6.3 Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

4.10.10.6.4 Public Health Agencies;

4.10.10.6.5 Schools;

4.10.10.6.6 The court system;

4.10.10.6.7 ServiceLink Resource Network;

4.10.10.6.8 2-1-1 NH;

4.10.10.6.9 Housing; and

4.10.10.6.10 VA Hospital and other programs and agencies serving service Members, veterans and their families.

4.10.10.7 The MCO shall report on the number of referrals for social services and community care provided to Members by Member type, consistent with the format and content requirements in accordance with Exhibit O.

4.11 Behavioral Health

4.11.1 **General Coordination Requirements**

4.11.1.1 This section describes the delivery and coordination of Behavioral Health Services and supports, for both mental health and Substance Use Disorder, delivered to children, youth and transition-aged youth/young adults, and adults.

4.11.1.2 The MCO shall deliver services in a manner that is both clinically and developmentally appropriate and that considers the Members, parents, caregivers and other networks of support the Member may rely upon.

4.11.1.3 The delivery of service shall be Member-centered and align with the principles of system of care and Recovery and resiliency.

4.11.1.4 The MCO shall provide Behavioral Health Services in accordance with this Agreement and all applicable State and federal laws and regulations.

4.11.1.5 The MCO shall be responsible for providing a full continuum of physical health and Behavioral Health Services; ensuring continuity and coordination between covered physical health and Behavioral Health Services; and requiring collaboration between physical health and behavioral health Providers.

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4.11.1.6 Consistent with He-M 425, the MCO shall be required to enter into a capitation model of contracting with CMH Programs and CMH Providers, which is essential to supporting the State's Delivery System Reform Incentive Payment Program (DSRIP) waiver and furthering physical and behavioral health integration in the MCM program.

4.11.1.7 The MCO shall comply with key administrative functions and processes, which may include, but are not limited to:

4.11.1.7.1 Processing timely prospective payment from a Member eligibility list provided by the CMH Program/CMH Provider;

4.11.1.7.2 Determining whether Members are eligible for the DHHS-required Capitation Payments, or should be paid on a FFS basis to the CMH Program/CMH Provider;

4.11.1.7.3 Providing detailed MCO data submissions to DHHS and the CMH Program or CMH Provider for purposes of reconciling payments and performance (e.g., 835 file);

4.11.1.7.4 Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs/CMH Providers (by region); and

4.11.1.7.5 All additional capabilities set forth by DHHS during the Readiness Review process.

4.11.1.8 Behavioral Health Subcontracts

4.11.1.8.1 If the MCO enters into a Subcontractor relationship with a behavioral health (mental health or Substance Use Disorder) Subcontractor to provide or manage Behavioral Health Services, the MCO shall provide a copy of the agreement between the MCO and the Subcontractor to DHHS for review and approval, including but not limited to any agreements with CMH Programs and CMH Providers as required in Section 4.11.5.1 (Contracting for Community Mental Health Services).

4.11.1.8.2 Such subcontracts shall address the coordination of services provided to Members by the Subcontractor, as well as the approach to Prior Authorization, claims payment, claims resolution, contract disputes, performance metrics, quality health outcomes, performance incentives, and reporting.

4.11.1.8.3 The MCO remains responsible for ensuring that all requirements of this Agreement are met, including requirements to ensure continuity and coordination between physical health and Behavioral Health Services, and that any Subcontractor adheres to

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all requirements and guidelines, as outlined in Section 3.14 (Subcontractors).

4.11.1.9 Promotion of Integrated Care

4.11.1.9.1 The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible.

4.11.1.9.2 In accordance with Exhibit O, the MCO shall include in its Behavioral Health Strategy Plan and Report efforts towards continued progression of the SAMHSA Integration Framework at all contracted primary and behavioral health Providers.

4.11.1.10 Approach to Behavioral Health Services

4.11.1.10.1 The MCO shall ensure that its clinical standard and operating procedures are consistent with trauma-informed models of care, as defined by SAMHSA²² and reflect a focus on Recovery and resiliency.²³

4.11.1.10.2 The MCO shall offer training inclusive of mental health first aid training, to MCO staff who manage the behavioral health contract and Participating Providers, including Care Managers, physical health Providers, and Providers on Recovery and resiliency, Trauma-Informed Care, and Community Mental Health Services and resources available within the applicable region(s).

4.11.1.10.3 The MCO shall track training rates and monitor usage of Recovery and resiliency and Trauma-Informed Care practices.

4.11.1.10.4 In accordance with Section 4.8.2 (Practice Guidelines and Standards), the MCO shall ensure that Providers, including those who do not serve behavioral health Members, are trained in Trauma-Informed models of Care.

4.11.1.11 Behavioral Health Strategy Plan and Report

4.11.1.11.1 The MCO shall submit to DHHS an initial plan describing its program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health

²² Substance Abuse and Mental Health Services Administration, "Trauma-Informed Approach and Trauma-Specific Interventions," available at <https://www.samhsa.gov/nctic/trauma-interventions>

²³ Substance Abuse and Mental Health Services Administration, "Recovery and Recovery Support," available at <https://www.samhsa.gov/recovery>

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Providers. In accordance with Exhibit O, the initial Plan shall address but not be limited to how the MCO shall:

4.11.1.11.1.1. Assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare;

4.11.1.11.1.2. Assure the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs;

4.11.1.11.1.3. Assure the promotion of Integrated Care;

4.11.1.11.1.4. Reduce Psychiatric Boarding described in Section 4.11.5.17 (Reducing Psychiatric Boarding);

4.11.1.11.1.5. Reduce Behavioral Health Readmissions described in Section 4.11.5.18.4 (Reduction in Behavioral Health Readmissions);

4.11.1.11.1.6. Support the NH 10-Year Plan outlined in Section 4.11.5.15 (Implementation of New Hampshire's 10-Year Mental Health Plan);

4.11.1.11.1.7. Assure the appropriateness of psychopharmacological medication;

4.11.1.11.1.8. Assure access to appropriate services;

4.11.1.11.1.9. Implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and

4.11.1.11.1.10. Other information in accordance with Exhibit O.

4.11.1.11.2 On an annual basis and in accordance with Exhibit O, the MCO shall provide an updated Behavioral Health Strategy Plan and Report which shall include an effectiveness analysis of the initial Plan's program, policies and procedures.

4.11.1.11.2.1. The analysis shall include MCO interventions which require improvement, including improvements in SAMHSA Standard Framework for Levels of Integrated Healthcare, continuity, coordination, and collaboration for physical health and Behavioral Health Services.

4.11.1.12 Collaboration with DHHS

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4.11.1.12.1 At the discretion of DHHS, the MCO shall provide mental health and Substance Use Disorder updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.1.12.2 To improve health outcomes for Members and ensure that delivery of services are provided at the appropriate intensity and duration, the MCO shall meet with behavioral health programs and DHHS at least four (4) times per year to discuss quality assurance activities conducted by the MCO, such as PIPs and APMs, and to review quality improvement plans and outstanding needs.

4.11.1.12.3 Quarterly meetings shall also include a review of progress against deliverables, improvement measures, and select data reports as detailed in Exhibit O. Progress and data reports shall be produced and exchanged between the MCO and DHHS two (2) weeks prior to each quarterly meeting.

4.11.1.12.4 At each meeting, the MCO shall update DHHS on the following topics:

4.11.1.12.4.1. Updates related to the MCO's Behavioral Health Strategy Report and interventions to improve outcomes;

4.11.1.12.4.2. [Amendment #5:] Intentionally left blank Results of the MCO's quarterly crisis line;

4.11.1.12.4.3. Utilization of ACT services and any waitlists for ACT services;

4.11.1.12.4.4. Current EBSE rates;

4.11.1.12.4.5. Current compliance with New Hampshire Hospital discharge performance standards;

4.11.1.12.4.6. Current compliance with ED discharge performance standards for overdoses and Substance Use Disorder;

4.11.1.12.4.7. Updates regarding services identified in Section 4.11 (Behavioral Health);

4.11.1.12.4.8. Updates on Mental Health and Substance Use Disorder PIPs; and

4.11.1.12.4.9. Other topics requested by DHHS.

4.11.1.12.5 For all Members, the MCO shall work in collaboration with DHHS and the NH Suicide Prevention Council to promote

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suicide prevention awareness programs, including the Zero Suicide program.

4.11.1.12.6 The MCO shall submit to DHHS, as specified by DHHS in Exhibit O, its implementation plan for incorporating the "Zero Suicide" program into its operations; the plan shall include, in addition to any other requirements specified in Exhibit O related to the plan, how the MCO shall:

4.11.1.12.6.1. Incorporate efforts to implement standardized provider screenings and other preventative measures; and

4.11.1.12.6.2. Incorporate the Zero Suicide Consensus Guide for Emergency Departments, as described in Section 4.8.2 (Practice Guidelines and Standards).

4.11.1.13 Primary Care Provider Screening for Behavioral Health Needs

4.11.1.13.1 The MCO shall ensure that the need for Behavioral Health Services is systematically identified by and addressed by the Member's PCP at the earliest possible time following initial enrollment of the Member and ongoing thereafter or after the onset of a condition requiring mental health and/or Substance Use Disorder treatment.

4.11.1.13.2 At a minimum, this requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to behavioral health Providers if clinically necessary.

4.11.1.13.3 The MCO shall encourage PCPs and other Providers to use a screening tool approved by DHHS, as well as other mechanisms to facilitate early identification of behavioral health needs.

4.11.1.13.4 The MCO shall require all PCPs and behavioral health Providers to incorporate the following domains into their screening and assessment process:

4.11.1.13.4.1. Demographic,

4.11.1.13.4.2. Medical,

4.11.1.13.4.3. Substance Use Disorder,

4.11.1.13.4.4. Housing,

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- 4.11.1.13.4.5. Family & support services,
- 4.11.1.13.4.6. Education,
- 4.11.1.13.4.7. Employment and entitlement,
- 4.11.1.13.4.8. Legal, and
- 4.11.1.13.4.9. Risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

4.11.1.13.5 The MCO shall require that pediatric Providers ensure that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

- 4.11.1.13.5.1. Depression screening (e.g., PHQ 2 & 9); and
- 4.11.1.13.5.2. Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

4.11.1.14 Referrals

4.11.1.14.1 The MCO shall ensure through its Health Risk Assessment Screening (described in Section 4.10.2) and its Risk Scoring and Stratification methodology that Members with a potential need for Behavioral Health Services, particularly Priority Population Members as described in Section 4.10.3 (Priority Populations), are appropriately and timely referred to behavioral health Providers if co-located care is not available.

4.11.1.14.2 This shall include education about Behavioral Health Services, including the Recovery process, Trauma-Informed Care, resiliency, CMH Programs/CMH Providers and Substance Use Disorder treatment Providers in the applicable region(s).

4.11.1.14.3 The MCO shall develop a referral process to be used by Participating Providers, including what information shall be exchanged and when to share this information, as well as notification to the Member's Care Manager.

4.11.1.14.4 The MCO shall develop and provide Provider education and training materials to ensure that physical health providers know

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when and how to refer Members who need specialty Behavioral Health Services.

4.11.1.14.5 The MCO shall ensure that Members with both physical health and behavioral health needs are appropriately and timely referred to their PCPs for treatment of their physical health needs when Integrated Care is not available.

4.11.1.14.6 The MCO shall develop a referral process to be used by its Providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health Provider.

4.11.1.14.7 The MCO shall develop and provide Provider education and training materials to ensure that behavioral health Providers know when and how to refer Members who need physical health services.

4.11.1.15 Prior Authorization

4.11.1.15.1 As of September, 2017, the MCO shall comply with the Prior Authorization requirements of House Bill 517 for behavioral health drugs, including use of the universal online Prior Authorization form provided by DHHS for drugs used to treat mental illness.

4.11.1.15.2 The MCO shall ensure that any Subcontractor, including any CMH Program/CMH Provider, complies with all requirements included in the bill.

4.11.1.16 Comprehensive Assessment and Care Plans for Behavioral Health Needs

4.11.1.16.1 The MCO's policies and procedures shall identify the role of physical health and behavioral health Providers in assessing a Member's behavioral health needs as part of the Comprehensive Assessment and developing a care plan.

4.11.1.16.2 For Members with chronic physical conditions that require ongoing treatment who also have behavioral health needs and who are not already treated by an integrated Provider team, the MCO shall ensure participation of the Member's physical health Provider (PCP or specialist), behavioral health Provider, and, if applicable, Care Manager, in the Comprehensive Assessment and care plan development process as well as the ongoing provision of services.

4.11.1.17 Written Consent

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4.11.1.17.1 Per 42 CFR Part 2 and NH Code of Administrative Rules, Chapter He-M 309, the MCO shall ensure that both the PCP and behavioral health Provider request written consent from Members to release information to coordinate care regarding mental health services or Substance Use Disorder services, or both, and primary care.

4.11.1.17.2 The MCO shall conduct a review of a sample of case files where written consent was required to determine if a release of information was included in the file.

4.11.1.17.3 The MCO shall report instances in which consent was not given, and, if possible, the reason why, and submit this report in accordance with Exhibit O.

4.11.1.18 Coordination Among Behavioral Health Providers

4.11.1.18.1 The MCO shall support communication and coordination between mental health and Substance Use Disorder service Providers and PCPs by providing access to data and information when the Member consent has been documented in accordance with State and federal law, including:

4.11.1.18.1.1. Assignment of a responsible party to ensure communication and coordination occur and that Providers understand their role to effectively coordinate and improve health outcomes;

4.11.1.18.1.2. Determination of the method of mental health screening to be completed by Substance Use Disorder service Providers;

4.11.1.18.1.3. Determination of the method of Substance Use Disorder screening to be completed by mental health service Providers;

4.11.1.18.1.4. Description of how treatment plans shall be coordinated among Behavioral Health Service Providers; and

4.11.1.18.1.5. Assessment of cross training of behavioral health Providers (i.e. mental health Providers being trained on Substance Use Disorder issues and Substance Use Disorder Providers being trained on mental health issues).

4.11.1.19 Member Service Line

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4.11.1.19.1 As further outlined in Section 4.4.4.3 (Member Call Center), the MCO shall operate a Member Services toll-free phone line that is used by all Members, regardless of whether they are calling about physical health or Behavioral Health Services.

4.11.1.19.2 The MCO shall not have a separate number for Members to call regarding Behavioral Health Services, but may either route the call to another entity or conduct a transfer to another entity after identifying and speaking with another individual at the receiving entity to accept the call (i.e., a "warm transfer").

4.11.1.19.3 If the MCO's nurse triage/nurse advice line is separate from its Member Services line, the nurse triage/nurse advice line shall be the same for all Members, regardless of whether they are calling about physical health and/or behavioral health term services.

4.11.1.20 Provision of Services Required by Courts

4.11.1.20.1 The MCO shall pay for all NH Medicaid State Plan services, to include assessment and diagnostic evaluations, for its Members as ordered by any court within the State. Court ordered treatment services shall be delivered at an appropriate level of care.

4.11.1.21 Sentinel Event Review

4.11.1.21.1 The MCO shall participate in sentinel event reviews conducted in accordance with the DHHS policy as requested by DHHS.

4.11.1.22 Behavioral Health Member Experience of Care Survey

4.11.1.22.1 The MCO shall contract with a third party to conduct a Member behavioral health experience of care survey on an annual basis.

4.11.1.22.2 The survey shall be designed by DHHS and the MCO's results shall be reported in accordance with Exhibit O. The survey shall comply with necessary NCQA Health Plan Accreditation standards.

4.11.2 Emergency Services

4.11.2.1 [Amendment #5] Intentionally left blank. ~~The MCO shall ensure, through its contracts with local Providers, that statewide crisis lines and Emergency Services are in place twenty-four (24) hours a day, seven (7) days a week for Members experiencing a mental health or Substance Use Disorder crisis.~~

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4.11.2.2 The MCO shall ensure that all types of behavioral health crisis response services are included, such as mobile crisis and office-based crisis services.

4.11.2.2.1 ~~[Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #7:] For the period July 1, 2021 through August 31, 2024 June 30, 2023 June 30, December 30, 2022, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.~~

4.11.2.3 Emergency Services shall be accessible to Members anywhere in the region served by the CMH Program/Provider.

4.11.2.4 ~~[Amendment #5] Described in Section 3.15.2 (Other MCO Required Staff), and pursuant to administrative rule, these crisis lines and Emergency Services teams shall employ clinicians and certified Peer Support Specialists.~~

4.11.2.5 ~~[Amendment #5] Intentionally left blank. The MCO shall be able to demonstrate during the Readiness Review process that its crisis line can effectively link Members to Emergency Services or other behavioral health crisis services and supports.~~

4.11.2.6 As directed by DHHS, and at the MCO's sole expense, the MCO shall contract with DHHS specified crisis service teams for both adults and children to meet these requirements.

4.11.2.7 At the discretion of DHHS, the MCO shall provide updates as requested by DHHS during regular Behavioral Health meetings between the MCO and DHHS on innovative and cost-effective models of providing mental health crisis and emergency response services that provide the maximum clinical benefit to the Member while also meeting DHHS's objectives to reduce admissions and increase community tenure.

4.11.2.8 ~~[Amendment #5] Intentionally left blank. In accordance with Exhibit O, the MCO shall submit quarterly crisis line data that lists the total calls received by the statewide crisis line attributable to Members, including the ultimate disposition of the call (e.g., educational, referral to care, no referral to care, etc.).~~

4.11.3 Behavioral Health Training Plan

4.11.3.1 In accordance with Exhibit O, the MCO shall develop a behavioral health training plan each year outlining how it will strengthen behavioral health capacity for Members within the state and support the efforts of CMH Programs/Providers to hire, retain and train qualified staff.

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4.11.3.2 The MCO shall coordinate with DHHS to reduce duplication of training efforts and submit the training plan to DHHS prior to program start and annually thereafter, inclusive of the training schedule and target Provider audiences.

4.11.3.3 As part of the training plan, the MCO shall promote Provider competence and opportunities for skill-enhancement through training opportunities and consultation, either through the MCO or other consultants with expertise in the area focused on through the training.

4.11.3.4 The MCO training plan shall include at least twenty-four (24) hours of training designed to sustain and expand the use of the:

4.11.3.4.1 Trauma Focused Cognitive Behavioral Therapy;

4.11.3.4.2 Trauma Informed Care;

4.11.3.4.3 Motivational Interviewing;

4.11.3.4.4 Interventions for Nicotine Education and Treatment;

4.11.3.4.5 Dialectical Behavioral Therapy (DBT);

4.11.3.4.6 Cognitive Behavioral Therapy;

4.11.3.4.7 Client Centered Treatment Planning;

4.11.3.4.8 Family Psychoeducation;

4.11.3.4.9 Crisis Intervention;

4.11.3.4.10 SBIRT for PCPs;

4.11.3.4.11 Depression Screening for PCPs;

4.11.3.4.12 Managing Cardiovascular and Metabolic Risk for People with SMI; and

4.11.3.4.13 MAT (including education on securing a SAMHSA waiver to provide MAT and, for Providers that already have such waivers, the steps required to increase the number of waiver slots).

4.11.3.5 The Training Plan shall also outline the MCO's plan to develop and administer the following behavioral health trainings for all Providers in all settings that are involved in the delivery of Behavioral Health Services to Members:

4.11.3.5.1 Training for primary care clinics on best practices for behavioral health screening and Integrated Care for common depression, anxiety and Substance Use Disorders;

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4.11.3.5.2 Training to physical health Providers on how and when to refer Members for Behavioral Health Services;

4.11.3.5.3 Training to behavioral health Providers on how and when to refer Members for physical health services;

4.11.3.5.4 Cross training to ensure that mental health Providers receive Substance Use Disorder training and Substance Use Disorder Providers receive mental health training;

4.11.3.5.5 New models for behavioral health interventions that can be implemented in primary care settings;

4.11.3.5.6 Clinical care integration models to Participating Providers; and

4.11.3.5.7 Community-based resources to address social determinants of health.

4.11.3.6 The MCO shall offer a minimum of two (2) hours of training each Agreement year to all contracted CMH Program/Provider staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the DHHS's objective of reducing the number of suicides in NH.

4.11.3.7 The MCO shall provide, on at least an annual basis, training on appropriate billing practices to Participating Providers. DHHS reserves the discretion to change training plan areas of focus in accordance with programmatic changes and objectives.

4.11.3.8 In accordance with Exhibit O, the MCO shall summarize in the annual Behavioral Health Strategy Plan and Report the training that was provided, a copy of the agenda for each training, a participant registration list, and a summary, for each training provided, of the evaluations done by program participants, and the proposed training for the next fiscal year.

4.11.4 Parity

4.11.4.1 The MCO and its Subcontractors shall comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438, subpart K, which prohibits discrimination in the delivery of mental health and Substance Use Disorder services and in the treatment of Members with, at risk for, or recovering from a mental health or Substance Use Disorder.

4.11.4.2 Semi-Annual Report on Parity

4.11.4.2.1 The MCO shall complete the DHHS Parity Compliance Report which shall include, at a minimum:

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4.11.4.2.1.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCO pursuant to DHHS criteria;

4.11.4.2.1.2. All Member grievances and appeals regarding a parity violation and resolutions;

4.11.4.2.1.3. The processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for mental health or Substance Use Disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for medical/surgical benefits in the same classification;

4.11.4.2.1.4. A comparison of payment for services that ensure comparable access for people with mental health diagnoses; and

4.11.4.2.1.5. Any other requirements identified in Exhibit O. [61 Fed. Reg. 18413, 18414 and 18417 (March 30, 2016)]

4.11.4.2.2 The MCO shall review its administrative and other practices, including those of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance issued by State and federal entities.

4.11.4.2.3 The MCO shall annually submit a certification signed by the CEO and chief medical officer (CMO) stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the MCO for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and federal Mental Health Parity Law and any guidance issued by State and federal entities.

4.11.4.2.4 If the MCO determines that any administrative, clinical, or utilization practices were not in compliance with relevant requirements of the federal Mental Health Parity Law or guidance issued by State and federal entities during the calendar year, the certification shall state that not all practices were in compliance with federal Mental Health Parity Law or any guidance issued by state or federal entities and shall include a list of the practices not in

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compliance and the steps the MCO has taken to bring these practices into compliance.

4.11.4.2.5 A Member enrolled in any MCO may file a complaint with DHHS at nhparity@dhhs.nh.gov if services are provided in a way that is not consistent with applicable federal Mental Health Parity laws, regulations or federal guidance.

4.11.4.2.6 As described in Section 4.4 (Member Services), the MCO shall describe the parity compliant process, including the appropriate contact information, in the Member Handbook.

4.11.4.3 Prohibition on Lifetime or Annual Dollar Limits

4.11.4.3.1 The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or Substance Use Disorder benefits. [42 CFR 438.905(b)]

4.11.4.4 Restrictions on Treatment Limitations

4.11.4.4.1 The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or Substance Use Disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits. [42 CFR 438.910(b)(1)]

4.11.4.4.2 The MCO shall not apply any cumulative financial requirements for mental health or Substance Use Disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. [42 CFR 438.910(c)(3)]

4.11.4.4.3 If an MCO Member is provided mental health or Substance Use Disorder benefits in any classification of benefit, the MCO shall provide mental health or Substance Use Disorder benefits to Members in every classification in which medical/surgical benefits are provided. [42 CFR 438.910(b)(2)]

4.11.4.4.4 The MCO shall not impose Non-Quantitative Treatment Limits for mental health or Substance Use Disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or Substance Use Disorder benefits in the classification are comparable to, and are applied no

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more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [42 CFR 438.910(d)]

4.11.4.5 Medical Necessity Determination

4.11.4.5.1 The MCO shall provide the criteria for medical necessity determinations for mental health or Substance Use Disorder benefits to any Member, potential Member, or Participating Provider upon request and at no cost.

4.11.5 Mental Health

4.11.5.1 Contracting for Community Mental Health Services

4.11.5.1.1 The MCO shall contract with CMH Programs and CMH Providers for the provision of Community Mental Health Services described in NH Code of Administrative Rules, Chapter He-M 426 on behalf of Medicaid Members who qualify for such services in accordance with He-M 401.24

4.11.5.1.2 The MCO's contract shall provide for monitoring of CMH Program/CMH Provider performance through quality metrics and oversight procedures of the CMH Program/CMH Provider.

4.11.5.1.3 The contract shall be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.14.2 (Contracts with Subcontractors). The contract shall, at minimum, address:

4.11.5.1.3.1. The scope of services to be covered;

4.11.5.1.3.2. Compliance with the requirements of this Agreement and all applicable State and federal laws, rules and regulations;

4.11.5.1.3.3. The role of the MCO versus the CMH Program/CMH Provider;

4.11.5.1.3.4. Procedures for communication and coordination between the MCO and the CMH Program/CMH Provider, other Providers serving the same Member and DHHS;

4.11.5.1.3.5. Data sharing on Members;

4.11.5.1.3.6. Data reporting between the CMH Program/CMH Provider and the MCO and DHHS; and

²⁴ Available at http://www.gencourt.state.nh.us/rules/About_Rules/listagencies.htm

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4.11.5.1.3.7. Oversight, enforcement, and remedies for contract disputes.

4.11.5.2 Payment to Community Mental Health Programs and Community Mental Health Providers

4.11.5.2.1 The MCO is required to enter into a capitated payment arrangement with CMH Programs to deliver Community Mental Health Services, providing for reimbursement on terms specified by DHHS in guidance.

4.11.5.2.2 The MCO shall reach agreements and enter into contracts with all CMH Programs that meet the terms specified by DHHS no later than ninety (90) calendar days after Agreement execution.

4.11.5.2.2.1. [Amendment #1:] For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in March 2019.
~~[Base Contract:] For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in January 2019.~~

4.11.5.2.3 [Amendment #5:] The MCO shall be subject to payment requirements described in Section 4.15.5 (Provider Payments: Community Mental Health Programs).

4.11.5.3 Provision of Community Mental Health Services

4.11.5.3.1 The MCO shall ensure that Community Mental Health Services are provided in accordance with the Medicaid State Plan and He-M 401.02, He-M 403.02 and He-M 426.

4.11.5.3.2 This includes, but is not limited, to ensuring that the full range of Community Mental Health Services are appropriately provided to eligible Members.

4.11.5.3.3 Eligible Members shall receive an individualized service plan created and updated regularly, consistent with State and federal requirements, including but not limited to He-M 401.

4.11.5.3.4 Eligible Members shall be offered the provisions of supports for illness self-management and Recovery;

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4.11.5.3.5 Eligible Members shall be provided with coordinated care when entering and leaving a designated receiving facility.

4.11.5.3.6 The MCO shall ensure that all Providers providing Community Mental Health Services comply with the requirements of He-M 426.

4.11.5.3.7 As described in He-M 400, a Member may be deemed eligible for Community Mental Health Services if the Member has a:

4.11.5.3.7.1. Severe or persistent mental illness (SPMI) for an adult;

4.11.5.3.7.2. SMI for an adult;

4.11.5.3.7.3. SPMI or SMI with low service utilization for an adult;

4.11.5.3.7.4. SED for a child; or

4.11.5.3.7.5. SED and interagency involvement for a child.

4.11.5.3.8 Any MCO quality monitoring or audits of the performance of the CMH Programs/CMH Providers shall be available to DHHS upon request.

4.11.5.3.9 To improve health outcomes for Members and ensure that the delivery of services is provided at the appropriate intensity and duration, the MCO shall meet with CMH Programs/CMH Providers and DHHS at least quarterly to coordinate data collection and ensure data sharing.

4.11.5.3.10 At a minimum, this shall include sharing of quality assurance activities conducted by the MCO and DHHS and a review of quality improvement plans, data reports, Care Coordination activities, and outstanding needs. Reports shall be provided in advance of quarterly meetings.

4.11.5.3.11 The MCO shall work in collaboration with DHHS, CMH Programs/CMH Providers to support and sustain evidenced-based practices that have a profound impact on Providers and Member outcomes.

4.11.5.4 Comprehensive Assessment and Care Plans

4.11.5.4.1 The MCO shall ensure, through its regular quality improvement activities, on-site reviews for children and youth, and reviews of DHHS administered quality service reviews for adults, that Community Mental Health Services are delivered in the least

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restrictive community based environment possible and based on a person-centered approach where the Member and his or her family's personal goals and needs are considered central in the development of the individualized service plans.

4.11.5.4.2 The MCO shall ensure that initial and updated care plans are based on a Comprehensive Assessment conducted using an evidenced-based assessment tool, such as the NH version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

4.11.5.4.3 If the MCO or a CMH Program/CMH Provider acting on behalf of the MCO elects to permit clinicians to use an evidenced-based assessment tool other than CANS or ANSA, the MCO shall notify and receive approval of the specific tool from DHHS.

4.11.5.4.4 The assessment shall include the domains of the DSRIP Comprehensive Core Standardized Assessment and elements under review in the DHHS quality service review.

4.11.5.4.5 The MCO shall ensure that clinicians conducting or contributing to a Comprehensive Assessment are certified in the use of NH's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within one hundred and twenty (120) calendar days of implementation by DHHS of a web-based training and certification system.

4.11.5.4.6 The MCO shall require that certified clinicians use the CANS, ANSA, or an alternative evidenced-based assessment tool approved by DHHS for any newly evaluated Member and for an existing Member no later than at the Member's first eligibility renewal following certification.

4.11.5.5 Assertive Community Treatment Teams

4.11.5.5.1 The MCO shall work in collaboration with DHHS and CMH Programs/CMH Providers to ensure that ACT teams include at least one certified Peer Support Specialist and are available to Medicaid Members twenty-four (24) hours a day, seven (7) days a week, with on-call availability from 12:00 am to 8:00 am.

4.11.5.5.2 At the sole discretion of DHHS, as defined in separate guidance, the MCO shall reimburse CMH Programs/CMH Providers at an enhanced rate for the cost of providing at least fair fidelity ACT services to eligible Medicaid Members.

4.11.5.5.3 The MCO shall obtain annual fidelity review reports from DHHS to inform the ACT team's adherence to fidelity.

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4.11.5.5.4 In collaboration with DHHS, the MCO shall support CMH Programs/CMH Providers to achieve program improvement goals outlined in the ACT Quality Improvement Plan on file with DHHS to achieve full implementation of ACT.

4.11.5.5.5 In accordance with Exhibit O, the MCO shall report quarterly on the rate at which the MCO's Medicaid Members eligible for Community Mental Health Services are receiving ACT services.

4.11.5.5.6 The MCO shall provide updates on any waitlists maintained for ACT services during regular behavioral health meetings between the MCO and DHHS.

4.11.5.6 Mental Health Performance Improvement Project

4.11.5.6.1 [Amendment #8:] As outlined in Section 4.12.3.7 (Performance Improvement Projects), the MCO shall focus on the Department's objectives outlined in the NH MCM Quality Strategy. engage in at least one (1) mental health PIP. The MCO shall satisfy this requirement by implementing a PIP designed to reduce Psychiatric Boarding in the ED.

4.11.5.7 Services for the Homeless

4.11.5.7.1 The MCO shall provide care to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services.

4.11.5.7.2 The MCO shall have one (1) or more Housing Coordinator(s) on staff or under contract to provide in-person housing assistance to Members who are homeless, as described in Section 3.15.1 (Key Personnel).

4.11.5.7.2.1. [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:]
For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ ~~2024~~, the Housing Coordinator position is not required.

4.11.5.7.3 The Housing Coordinator(s) shall coordinate with housing case managers at the CMH Programs, New Hampshire Hospital, the Bureau of Mental Health Services, the Bureau of Housing Supports and other CMH Providers to coordinate referrals.

4.11.5.7.4 In coordination with CMH Programs/CMH Providers, the MCO shall ensure that ACT teams and/or Housing Coordinator(s)

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also provide ongoing mental health and tenancy support services to Members.

4.11.5.7.5 In its contract with CMH Programs/CMH Providers, the MCO shall describe how it shall provide appropriate oversight of CMH Program/CMH Provider responsibilities, including:

4.11.5.7.5.1. Identifying housing options for Members at risk of experiencing homelessness;

4.11.5.7.5.2. Assisting Members in filing applications for housing and gathering necessary documentation;

4.11.5.7.5.3. Coordinating the provision of supportive housing; and

4.11.5.7.5.4. Coordinating housing-related services amongst CMH Programs/CMH Providers, the MCO and NH's Housing Bridge Subsidy Program.

4.11.5.7.6 The contract with CMH Programs/CMH Providers shall require quarterly assessments and documentation of housing status and homelessness for all Members.

4.11.5.7.7 The MCO shall ensure that any Member discharged into homelessness is connected to Care Management as described in Section 4.10.10 (Coordination and Integration with Social Services and Continuity of Care) within twenty-four (24) hours upon release.

4.11.5.8 Supported Employment

4.11.5.8.1 In coordination with CMH Programs/CMH Providers, the MCO shall actively promote EBSE to eligible Members.

4.11.5.8.2 The MCO shall obtain fidelity review reports from DHHS to inform EBSE team's adherence to fidelity with the expectation of at least good fidelity implementation for each CMH Program/CMH Provider.

4.11.5.8.3 In collaboration with DHHS, the MCO shall support the CMH Programs and CMH Providers to achieve program improvement goals outlined in the EBSE Quality Improvement Plan on file with DHHS to achieve full implementation of EBSE.

4.11.5.8.4 Based on data provided by DHHS, the MCO shall support DHHS's goals to ensure that at least nineteen percent (19%) of adult Members are engaged in EBSE services and that employment status is updated by the CMH Program/CMH Provider on a quarterly basis.

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4.11.5.8.5 The MCO shall report the EBSE rate to DHHS in accordance with Exhibit O and provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.9 Illness Management and Recovery

4.11.5.9.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of and increased penetration rates of illness management and Recovery to Members with SMI and SPMI.

4.11.5.9.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.10 Dialectical Behavioral Therapy

4.11.5.10.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of DBT to Members with diagnoses, including but not limited to SMI, SPMI, and Borderline Personality Disorder.

4.11.5.10.2 The MCO shall provide updates, such as the rate at which eligible Members receive meaningful levels of DBT services, as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.11 Peer Recovery Support Services

4.11.5.11.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of PRSS provided by Peer Recovery Programs in a variety of settings such as CMH Programs, New Hampshire Hospital, primary care clinics, and EDs.

4.11.5.11.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.12 Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems

4.11.5.12.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems²⁵ for children and youth Members experiencing anxiety, depression, trauma and conduct issues.

²⁵Available at: http://www.practicewise.com/portals/0/match_public/index.html

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4.11.5.12.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.13 First Episode Psychosis

4.11.5.13.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of programming to address early symptoms of psychosis.

4.11.5.13.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.14 Child Parent Psychotherapy

4.11.5.14.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote delivery of Child Parent Psychotherapy for young children.

4.11.5.14.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.15 Implementation of New Hampshire's 10-Year Mental Health Plan

4.11.5.15.1 In accordance with Exhibit O, the MCO shall actively support the implementation of NH's 10-Year Mental Health Plan, updated periodically, to reinforce implementation of priorities outlined in the plan.

4.11.5.16 Changes in Healthy Behavior

4.11.5.16.1 The MCO shall promote Community Mental Health Service recipients' whole health goals to address health disparities.

4.11.5.16.2 Efforts can encompass interventions (e.g., tobacco cessation, "InShape") or other efforts designed to improve health.

4.11.5.16.3 The MCO shall gather smoking status data on all Members and report to DHHS in accordance with Exhibit O.

4.11.5.16.4 The MCO shall support CMH Programs/CMH Providers to establish incentive programs for Members to increase their engagement in healthy behavior change initiatives.

4.11.5.17 Reducing Psychiatric Boarding

4.11.5.17.1 For each hospital in its network, the MCO shall have on its own staff or contract with clinical Providers who are credentialed

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by the hospital (i.e., "hospital-credentialed Providers") to provide services to reduce Psychiatric Boarding stays.

4.11.5.17.1.1. [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30, December 31, 2022~~ 2024, the Psychiatric Boarding program's hospital-credentialed Provider position(s) described in Sections 4.11.5.17.1 through 4.11.5.17.4, and 4.11.5.17.6 are not required.

4.11.5.17.2 In meeting this requirement, the MCO cannot use CMH Programs and CMH Providers and shall ensure that its hospital-credentialed Providers are in addition to any capacity provided by CMH Programs and CMH Providers.

4.11.5.17.3 The MCO shall supply a sufficient number of hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to, or at risk for, Psychiatric Boarding.

4.11.5.17.4 The number of such hospital-credentialed Providers shall be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed.

4.11.5.17.5 [Amendment #8:] The initial on-site assistance provided within these required timelines shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or other State determined IMDs for mental illness or Substance Use Disorder services.

4.11.5.17.6 Each such hospital-credentialed Provider shall have the clinical expertise, inclusive of prescribing authority, to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required.

4.11.5.17.7 At the request of DHHS, the MCO shall participate in meetings with hospitals to address Psychiatric Boarding.

4.11.5.17.8 The MCO shall pay no less than the rate paid by NH Medicaid FFS program for all inpatient and outpatient service categories for billable services related to psychiatric boarding.

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4.11.5.17.9 [Amendment #8:] The MCO's capitation rates related to psychiatric services shall reflect utilization levels consistent with best practices for clinical path protocols, ED Psychiatric Boarding services, and discharge/readmission management at or from New Hampshire Hospital or other State determined IMDs for mental illness or Substance Use Disorder services.

4.11.5.17.10 The MCO shall describe its plan for reducing Psychiatric Boarding in its Annual Behavioral Health Strategy Plan and Report, in accordance with Exhibit O.

4.11.5.17.11 At minimum, the plan shall address how:

4.11.5.17.11.1. The MCO identifies when its Members are in the ED awaiting psychiatric placement or in a hospital setting awaiting an inpatient psychiatric bed;

4.11.5.17.11.2. Policies for ensuring a prompt crisis team consultation and face-to-face evaluation;

4.11.5.17.11.3. Strategies for identifying placement options or alternatives to hospitalization; and

4.11.5.17.11.4. Coordination with the CMH Programs/CMH Providers serving Members.

4.11.5.17.12 In accordance with Exhibit O, the MCO shall provide a monthly report on the number of its Members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult Members, and the rate of recidivism for Psychiatric Boarding.

4.11.5.18 [Amendment #8:] New Hampshire Hospital and Other State Determined IMDs for Mental Illness

4.11.5.18.1 [Amendment #8:] Agreements for New Hampshire Hospital Agreement and Other State Determined IMDs for Mental Illness

4.11.5.18.1.1. [Amendment #8:] The MCO shall maintain a written collaborative agreement with New Hampshire Hospital, ~~NH's State operated inpatient psychiatric facility~~ and other State determined IMDs for mental illness.

4.11.5.18.1.2. [Amendment #8:] This collaborative agreement shall be subject to the approval of DHHS and shall address the ADA requirement that Members be

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served in the most integrated setting appropriate to their needs, include the responsibilities of the CMH Program/CMH Provider to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital and other State determined IMDs for mental illness.

4.11.5.18.1.3. [Amendment #8:] The collaborative agreement shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to New Hampshire Hospital and other State determined IMDs for mental illness.

4.11.5.18.1.4. [Amendment #8:] Prior to admission to New Hampshire Hospital or other State determined IMDs for mental illness, the MCO shall ensure that a crisis team consultation has been completed for all Members evaluated by a licensed physician or psychologist.

4.11.5.18.1.5. The MCO shall ensure that a face-to-face evaluation by a mandatory pre-screening agent is conducted to assess eligibility for emergency involuntary admission to New Hampshire Hospital and determine whether all available less restrictive alternative services and supports are unsuitable.

4.11.5.18.2 Discharge Planning

4.11.5.18.2.1. [Amendment #8:] It is the policy of DHHS to avoid discharges from inpatient care at New Hampshire Hospital or other State determined IMDs for mental illness, to homeless shelters and to ensure the inclusion of an appropriate living situation as an integral part of all discharge planning ~~from New Hampshire Hospital.~~

4.11.5.18.2.2. The MCO shall track any Member discharges that the MCO, through its Provider network, was unable to place into the community and Members who instead were discharged to a shelter or into homelessness.

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4.11.5.18.2.3. [Amendment #8:] Also included in Section 3.15.2 (Other MCO Required Staff), the MCO shall designate an off-site ~~on-site~~ liaison with privileges, ~~as required by New Hampshire Hospital,~~ to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to New Hampshire Hospital or other State determined IMDs for mental illness.

4.11.5.18.2.4. [Amendment #8:] Except for participation in the Administrative Review Committee, the liaison shall actively participate in New Hampshire Hospital and other State determined IMDs for mental illness treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least restrictive environment complying with the ADA and other applicable State and federal regulations.

4.11.5.18.2.5. [Amendment #8:] The liaison shall actively participate, and assist New Hampshire Hospital and other State determined IMDs for mental illness staff in the development of a written discharge plan within twenty-four (24) hours of admission.

4.11.5.18.2.6. [Amendment #8:] The MCO shall ensure that the final New Hampshire Hospital or other State determined IMDs for mental illness discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight percent (98%) of Members discharged.

4.11.5.18.2.7. The MCO shall ensure that the discharge progress note shall be provided to the aftercare Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.11.5.18.2.8. For ACT team service recipients, the MCO shall ensure that the discharge progress note is provided to the Provider within twenty-four (24) hours of Member discharge.

4.11.5.18.2.9. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

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4.11.5.18.2.10. [Amendment #8:] The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from New Hampshire Hospital and other State determined IMDs for mental illness in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.11.5.18.2.11. The performance metric shall be that one hundred percent (100%) of Members discharged shall have been attempted to be contacted within three (3) business days.

4.11.5.18.2.12. For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the aftercare Provider and request that the aftercare Provider make contact with the Member within twenty-four (24) hours.

4.11.5.18.2.13. The MCO shall ensure an appointment with a CMH Program/CMH Provider or other appropriate mental health clinician is scheduled and that transportation has been arranged for the appointment prior to discharging a Member.

4.11.5.18.2.14. Such appointment shall occur within seven (7) calendar days after discharge.

4.11.5.18.2.15. ACT team service recipients shall be seen within twenty-four (24) hours of discharge.

4.11.5.18.2.16. For persons discharged from psychiatric hospitalization who are not a current client of the applicable CMH Program/CMH Provider, the Member shall have an intake appointment that is scheduled to occur within seven (7) calendar days after discharge.

4.11.5.18.2.17. [Amendment #8:] The MCO shall work with DHHS and the applicable CMH Program/CMH Provider to review cases of Members that New Hampshire Hospital and other State determined IMDs for mental illness ~~has~~ have indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

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4.11.5.18.3 Administrative Days and Post Stabilization Care Services

4.11.5.18.3.1. [Amendment #8:] The MCO shall perform in-reach activities to New Hampshire Hospital and other State determined IMDs for mental illness designed to accomplish transitions to the community.

4.11.5.18.3.2. [Amendment #8:] Administrative days and post stabilization care services are inpatient hospital days associated with Members who no longer require acute care but are left in New Hampshire Hospital and other State determined IMDs for mental illness. ~~the hospital.~~

4.11.5.18.3.3. [Amendment #8:] The MCO shall pay New Hampshire Hospital and other State determined IMDs for mental illness for services delivered under the inpatient and outpatient service categories at rates no less than those paid by the NH Medicaid FFS program, inclusive of both State and federal share of the payment, if a Member cannot be discharged due to failure to provide appropriate community-based care and services.

4.11.5.18.4 Reduction in Behavioral Health Readmissions

4.11.5.18.4.1. [Amendment #8:] The MCO shall describe a reduction in readmissions plan in its annual Behavioral Health Strategy Plan and Report in accordance with Exhibit O, subject to approval by DHHS, to monitor the thirty (30)-day and one hundred and eighty (180)-day readmission rates to New Hampshire Hospital, other State determined IMDs for mental illness, designated receiving facilities and other equivalent facilities to review Member specific data with each of the CMH Programs/CMH Providers, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce thirty (30)-day and one hundred and eighty (180)-day readmission.

4.11.5.18.4.2. [Amendment #8:] Avoiding readmission is associated with the delivery of a full array of Medically Necessary outpatient medication and Behavioral Health Services in the ninety (90) days after discharge from New Hampshire Hospital and other State determined

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IMDs for mental illness; the MCO shall ensure provision of appropriate service delivery in the ninety (90) days after discharge.

4.11.5.18.4.3. [Amendment #8:] For Members with readmissions to any inpatient psychiatric setting within thirty (30) days and one hundred and eighty (180) days, the MCO shall report on the mental health and related service utilization that directly preceded readmission in accordance with Exhibit O. This data shall be shared with the Member's CMH Program/CMH Provider, if applicable, and DHHS in order to evaluate if appropriate levels of care were provided to decrease the likelihood of re-hospitalization.

4.11.6 Substance Use Disorder

4.11.6.1 The MCO's policies and procedures related to Substance Use Disorder shall be in compliance with State and federal law, including but not limited to, Chapter 420-J, Section J:15 through Section J:19 and shall comply with all State and federal laws related to confidentiality of Member behavioral health information.

4.11.6.2 In addition to services covered under the Medicaid State Plan, the MCO shall cover the services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder benefits. [42 CFR 438, subpart K; 42 CFR 438.3(e)(1)(ii)]

4.11.6.3 The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.11.6.4 Contracting for Substance Use Disorder

4.11.6.4.1 The MCO shall contract with Substance Use Disorder service programs and Providers to deliver Substance Use Disorder services for eligible Members, as defined in He-W 513.²⁶

4.11.6.4.2 The contract between the MCO and the Substance Use Disorder programs and Participating Providers shall be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.14.2 (Contracts with Subcontractors).

4.11.6.4.3 The contract shall, at minimum, address the following:

4.11.6.4.3.1. The scope of services to be covered;

²⁶ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html

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4.11.6.4.3.2. Compliance with the requirements of this Agreement and applicable State and federal law;

4.11.6.4.3.3. The role of the MCO versus the Substance Use Disorder program and/or Provider;

4.11.6.4.3.4. procedures for communication and coordination between the MCO and the Substance Use Disorder program and/or Provider;

4.11.6.4.3.5. Other Providers serving the same Member, and DHHS as applicable;

4.11.6.4.3.6. The approach to payment, including enhanced payment for ACT services;

4.11.6.4.3.7. Data sharing on Members;

4.11.6.4.3.8. Data reporting between the Substance Use Disorder programs and/or Providers and the MCO, and DHHS as applicable; and

4.11.6.4.3.9. Oversight, enforcement, and remedies for contract disputes.

4.11.6.4.4 The contract shall provide for monitoring of Substance Use Disorder service performance through quality metrics and oversight procedures specified in the contract.

4.11.6.4.5 When contracting with Peer Recovery Programs, the MCO shall contract with all Willing Providers in the State through the PRSS Facilitating Organization or other accrediting body approved by DHHS, unless the Provider requests a direct contract.

4.11.6.4.6 The MCO shall reimburse Peer Recovery Programs in accordance with rates that are no less than the equivalent DHHS FFS rates.

4.11.6.4.7 When contracting with methadone clinics, the MCO shall contract with and have in its network all Willing Providers in the state.

4.11.6.5 Payment to Substance Use Disorder Providers

4.11.6.5.1 The MCO shall reimburse Substance Use Disorder Providers in accordance with rates that are no less than the equivalent DHHS FFS rates.

4.11.6.5.2 The MCO need not pay using DHHS's FFS mechanism where the MCO's contract with the Provider meets the following requirements:

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4.11.6.5.2.1. Is subject to enhanced reimbursement for MAT, as described in as outlined in this section; or

4.11.6.5.2.2. Falls under a DHHS-approved APM, the standards and requirements for obtaining DHHS approval are further described in Section 4.14 (Alternative Payment Models).

4.11.6.5.3 DHHS shall provide the MCO with sixty (60) calendar days' advance notice prior to any change to reimbursement.

4.11.6.5.4 In accordance with Exhibit O, the MCO shall develop and submit to DHHS, a payment plan for offering enhanced reimbursement to qualified physicians who are SAMHSA certified to dispense or prescribe MAT.

4.11.6.5.5 The plan shall indicate at least two (2) tiers of enhanced payments that the MCO shall make to qualified Providers based on whether Providers are certified and providing MAT to up to thirty (30) Members per quarter (i.e., tier one (1) Providers) or certified and providing MAT to up to one hundred (100) Members per quarter (i.e., tier two (2) Providers).

4.11.6.5.6 The tier determinations that qualify Providers for the MCO's enhanced reimbursement policy shall reflect the number of Members to whom the Provider is providing MAT treatment services, not the number of patients the Provider is certified to provide MAT treatment to.

4.11.6.5.7 The MCO shall develop at least one (1) APM designed to increase access to MAT for Substance Use Disorder and one (1) APM (such as a bundled payment) for the treatment of babies born with NAS.

4.11.6.6 Provision of Substance Use Disorder Services

4.11.6.6.1 The MCO shall ensure that Substance Use Disorder services are provided in accordance with the Medicaid State Plan and He-W 513. This includes, but is not limited to:

4.11.6.6.1.1. Ensuring that the full continuum of care is appropriately provided to eligible Members;

4.11.6.6.1.2. Ensuring that eligible Members are provided with Recovery support services; and

4.11.6.6.1.3. Ensuring that eligible Members are provided with coordinated care when entering or leaving a treatment program.

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4.11.6.6.2 The MCO shall ensure that all Providers providing Substance Use Disorder services comply with the requirements of He-W 513.

4.11.6.6.3 The MCO shall work in collaboration with DHHS and Substance Use Disorder programs and/or Providers to support and sustain evidenced-based practices that have a profound impact on Provider and Member outcomes, including, but is not limited to, enhanced rate or incentive payments for evidenced-based practices.

4.11.6.6.4 The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.11.6.6.5 This includes, but is not limited to:

4.11.6.6.5.1. Ensuring that Members at risk of experiencing Substance Use Disorder are assessed using a standardized evidence-based assessment tool consistent with ASAM Criteria; and

4.11.6.6.5.2. Providing access to the full range of services available under the DHHS's Substance Use Disorder benefit, including Peer Recovery Support without regard to whether Peer Recovery Support is an aspect of an additional service provided to the Member.

4.11.6.6.6 The MCO shall make PRSS available to Members both as a standalone service (regardless of an assessment), and as part of other treatment and Recovery services.

4.11.6.6.7 The provision of services to recipients enrolled in an MCO shall not be subject to more stringent service coverage limits than specified under this Agreement or State Medicaid policies.

4.11.6.7 Substance Use Disorder Clinical Evaluations and Treatment Plans

4.11.6.7.1 The MCO shall ensure, through its regular quality improvement activities and reviews of DHHS administered quality monitoring and improvement activities, that Substance Use Disorder treatment services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and their family's personal goals and needs are considered central in the development of the Individualized service plans.

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4.11.6.7.2 A Clinical Evaluation is a biopsychosocial evaluation completed in accordance with SAMHSA Technical Assistance Publication (TAP) 21: Addiction Counseling Competencies.

4.11.6.7.3 The MCO shall ensure that all services provided include a method to obtain clinical evaluations using DSM five (5) diagnostic information and a recommendation for a level of care based on the ASAM Criteria, published in October, 2013 or as revised by ASAM.

4.11.6.7.4 The MCO shall ensure that a clinical evaluation is completed for each Member prior to admission as a part of interim services or within three (3) business days following admission.

4.11.6.7.5 For a Member being transferred from or otherwise referred by another Provider, the Provider shall use the clinical evaluation completed by a licensed behavioral health professional from the referring agency, which may be amended by the receiving Provider.

4.11.6.7.6 The Provider shall complete individualized treatment plans for all Members based on clinical evaluation data within three (3) business days of the clinical evaluation, that address problems in all ASAM 2013 domains which justify the Member's admittance to a given level of care and that include individualized treatment plan goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART).

4.11.6.7.7 The treatment plan shall include the Member's involvement in identifying, developing, and prioritizing goals, objectives, and interventions.

4.11.6.7.8 Treatment plans shall be updated based on any changes in any ASAM domain and no less frequently than every four (4) sessions or every four (4) weeks, whichever is less frequent.

4.11.6.7.9 The treatment plan updates much include:

4.11.6.7.9.1. Documentation of the degree to which the Member is meeting treatment plan goals and objectives;

4.11.6.7.9.2. Modification of existing goals or addition of new goals based on changes in the Member's functioning relative to ASAM domains and treatment goals and objectives;

4.11.6.7.9.3. The counselor's assessment of whether or not the Member needs to move to a different level of

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care based on ASAM continuing care, transfer and discharge criteria; and

4.11.6.7.9.4. The signature of the Member and the counselor agreeing to the updated treatment plan, or if applicable, documentation of the Member's refusal to sign the treatment plan.

4.11.6.8 Substance Use Disorder Performance Improvement Project

4.11.6.8.1 In compliance with the requirements outlined in Section 4.12.3 (Quality Assessment and Performance Improvement Program), the MCO shall, at a minimum, conduct at least one (1) PIP designed to improve the delivery of Substance Use Disorder services.

4.11.6.9 Reporting

4.11.6.9.1 The MCO shall report to DHHS Substance Use Disorder-related metrics in accordance with Exhibit O including, but not limited to, measures related to access to services, engagement, clinically appropriate services, Member engagement in treatment, treatment retention, safety monitoring, and service utilization.

4.11.6.9.2 The MCO shall provide, in accordance with Exhibit O, an assessment of any prescribing rate and pattern outliers and how the MCO plans to follow up with Providers identified as having high-prescribing patterns.

4.11.6.9.3 [Amendment #7:] The MCO shall utilize audit tool(s) provided by or approved by DHHS, collected via one or more mediums made available or approved by DHHS, to assess the activities of Substance Use Disorder Providers and Opioid Treatment Programs (OTPs), to ensure compliance with the He-W 513 rules, He-A 304 rules, and the MCO Contract. The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.11.6.9.3.1. [Amendment #7:] The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.11.6.9.3.2. [Amendment #7:] The MCO shall report on SUD Provider compliance with service provisions

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outlined in the SUD audit tool in accordance with Exhibit O.

4.11.6.9.4 On a monthly basis, the MCO shall provide directly to Participating Providers comparative prescribing data, including the average Morphine Equivalent Dosing (MED) levels across patients and identification of Members with MED at above average levels, as determined by the MED levels across Members.

4.11.6.9.5 The MCO shall also provide annual training to Participating Providers.

4.11.6.10 Services for Members Who are Homeless or At-Risk of Homelessness

4.11.6.10.1 In coordination with Substance Use Disorder programs and/or Providers, the MCO shall provide care to Members who are homeless or at risk of homelessness as described in Section 4.11.5.7 (Services for the Homeless).

4.11.6.11 Peer Recovery Support Services

4.11.6.11.1 In coordination with Peer Recovery Programs and Peer Recovery Coaches, as defined in He-W 513, the MCO shall actively promote delivery of PRSS provided by Peer Recovery Coaches who are also certified Recovery support workers in a variety of settings such as Peer Recovery Programs, clinical Substance Use Disorder programs, EDs, and primary care clinics.

4.11.6.12 Naloxone Availability

4.11.6.12.1 The MCO shall work with each contracted Substance Use Disorder program and/or Provider to ensure that naloxone kits are available on-site and training on naloxone administration and emergency response procedures are provided to program and/or Provider staff at a minimum annually.

4.11.6.13 Prescription Drug Monitoring Program

4.11.6.13.1 The MCO shall include in its Provider agreements the requirement that prescribers and dispensers comply with the NH PDMP requirements, including but not limited to opioid prescribing guidelines.

4.11.6.13.2 The Provider agreements shall require Participating Providers to provide to the MCO, to the maximum extent possible, data on substance dispensing to Members prior to releasing such medications to Members.

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4.11.6.13.3 The MCO shall monitor harmful prescribing rates and, at the discretion of DHHS, may be required to provide ongoing updates on those Participating Providers who have been identified as overprescribing.

4.11.6.14 Response After Overdose

4.11.6.14.1 Whenever a Member receives emergency room or inpatient hospital services as a result of a non-fatal overdose, the MCO shall work with hospitals to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and the participating hospital.

4.11.6.14.2 Whenever a Member discharges themselves against medical advice, the MCO shall make a good faith effort to ensure that the Member receives a clinical evaluation, referral to appropriate treatment, Recovery support services and intense Case Management within forty-eight (48) hours of discharge or the MCO being notified, whichever is sooner.

4.11.6.15 Limitations on Prior Authorization Requirements

4.11.6.15.1 To the extent permitted under State and federal law, the MCO shall cover MAT.

4.11.6.15.2 Methadone received at a methadone clinic shall not require Prior Authorization.

4.11.6.15.3 Methadone used to treat pain shall require Prior Authorization.

4.11.6.15.3.1. Any Prior Authorization for office based MAT shall comply with RSA 420-J:17 and RSA 420-J:18.

4.11.6.15.4 The MCO shall not impose any Prior Authorization requirements for MAT urine drug screenings (UDS) unless a Provider exceeds thirty (30) UDSs per month per treated Member.

4.11.6.15.4.1. In the event a Provider exceeds thirty (30) UDS per month per treated Member, the MCO shall impose Prior Authorization requirements on usage.

4.11.6.15.5 The MCO is precluded from imposing any Prior Authorization on screening for multiple drugs within a daily drug screen.

4.11.6.15.6 [Amendment #6:] The MCO may require prior authorization for SUD treatments, excluding MAT services as

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~~described in Section 4.11.6.15.3.1. The MCO shall cover without Prior Authorization or other Utilization Management restrictions any treatments identified as necessary by a clinician trained in the use and application of the ASAM Criteria.~~

4.11.6.15.6.1. [Amendment #6:] The MCO shall utilize ASAM Criteria when determining medical necessity for continuation of covered services.

4.11.6.15.6.2. [Amendment #6:] Nothing in this section shall be construed to require coverage for services provided by a non-participating provider.

4.11.6.15.6.3. [Amendment #6:] The MCO may require prior authorization for covered services only if the MCO has a medical clinician or licensed alcohol and drug counselor available on a 24-hour hotline to make the medical necessity determination and assist with placement at the appropriate level of care, and the MCO provides a prior authorization decision as soon as practicable after receipt from the treating clinician of the clinical rationale consistent with the ASAM criteria, but in no event more than 6 hours of receiving such information; provided that until such hotline determination is made, coverage for substance use disorder services shall be provided at an appropriate level of care consistent with the ASAM criteria, as defined in RSA 420-J:15, I.

4.11.6.15.7 [Amendment #6:] Intentionally left blank. Should the MCO have concerns about the appropriateness of a course of treatment after the treatment has commenced, the MCO shall contact the Provider to request additional information and/or recommend a change, but shall continue to pay for the treatment unless and until the Provider determines an alternative type of treatment or setting is appropriate.

4.11.6.15.8 DHHS shall monitor utilization of Substance Use Disorder treatment services to identify, prevent, and correct potential occurrences of fraud, waste and abuse, in accordance with 42 CFR 455 and 42 CFR 456 and He-W 520.

4.11.6.15.9 DHHS may grant exceptions to this provision in instances where it is necessary to prevent fraud, waste and abuse.

4.11.6.15.10 For Members who enter the Pharmacy Lock-In Program as described in Section 4.2.3 (Clinical Policies and Prior

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Authorizations), the MCO shall evaluate the need for Substance Use Disorder treatment.

4.11.6.16 Opioid Prescribing Requirements

4.11.6.16.1 The MCO shall require Prior Authorization documenting the rationale for the prescriptions of more than one hundred (100) mg daily MED of opioids for Members.

4.11.6.16.2 As required under the NH Board Administrative Rule MED 502 Opioid Prescribing, the MCO shall adhere to MED procedures for acute and chronic pain, taking actions, including but not limited to:

4.11.6.16.2.1. A pain management consultation or certification from the Provider that it is due to an acute medical condition;

4.11.6.16.2.2. Random and periodic UDS; and

4.11.6.16.2.3. Utilizing written, informed consent.

4.11.6.16.3 The MCO shall ensure that Participating Providers prescribe and dispense Naloxone for patients receiving a one hundred (100) mg MED or more per day for longer than ninety (90) calendar days.

4.11.6.16.4 If the NH Board Administrative Rule MED 502 Opioid Prescribing is updated in the future, the MCO shall implement the revised policies in accordance with the timelines established or within sixty (60) calendar days if no such timeline is provided.

4.11.6.17 Neonatal Abstinence Syndrome

4.11.6.17.1 For those Members with a diagnosis of Substance Use Disorder and all infants with a diagnosis of NAS, or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall provide Care Management services to provide for coordination of their physical and behavioral health, according to the safeguards relating to re-disclosure set out in 42 CFR Part 2.

4.11.6.17.2 Substance Use Disorder Care Management features shall include, but not be limited to:

4.11.6.17.2.1. Conducting outreach to Members who would benefit from treatment (for example, by coordinating with emergency room staff to identify and engage with Members admitted to the ED following an overdose),

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4.11.6.17.2.2. Ensuring that Members are receiving the appropriate level of Substance Use Disorder treatment services,

4.11.6.17.2.3. Scheduling Substance Use Disorder treatment appointments and following up to ensure appointments are attended, and

4.11.6.17.2.4. Coordinating care among prescribing Providers, clinician case managers, pharmacists, behavioral health Providers and social service agencies.

4.11.6.17.2.5. The MCO shall make every attempt to coordinate and enhance Care Management services being provided to the Member by the treating Provider.

4.11.6.17.3 The MCO shall work with DCYF to provide Substance Use Disorder treatment referrals and conduct a follow-up after thirty (30) calendar days to determine the outcome of the referral and determine if additional outreach and resources are needed.

4.11.6.17.4 The MCO shall work with DCYF to ensure that health care Providers involved in the care of infants identified as being affected by prenatal drug or alcohol exposure, create and implement the Plan of Safe Care.

4.11.6.17.4.1. The Plan of Safe Care shall be developed in collaboration with health care Providers and the family/caregivers of the infant to address the health of the infant and Substance Use Disorder treatment needs of the family or caregiver.

4.11.6.17.5 The MCO shall establish protocols for Participating Providers to implement a standardized screening and treatment protocol for infants at risk of NAS.

4.11.6.17.6 The MCO shall provide training to Providers serving infants with NAS on best practices, including:

4.11.6.17.6.1. Opportunities for the primary care giver(s) to room-in;

4.11.6.17.6.2. Transportation and childcare for the primary care giver(s);

4.11.6.17.6.3. Priority given to non-pharmaceutical approaches (e.g., quiet environment, swaddling);

4.11.6.17.6.4. Education for primary care giver(s) on caring for newborns;

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4.11.6.17.6.5. Coordination with social service agencies providing supports, including coordinated case meetings and appropriate developmental services for the infant;

4.11.6.17.6.6. Information on family planning options; and

4.11.6.17.6.7. Coordination with the family and Providers on the development of the Plan of Safe Care for any infant born with NAS.

4.11.6.17.7 The MCO shall work with DHHS and Providers eligible to expand/develop services to increase capacity for specialized services for this population which address the family as a unit and are consistent with Northern New England Perinatal Quality Improvement Network's (NNEPQIN) standards.

4.11.6.18 Discharge Planning

4.11.6.18.1 In all cases where the MCO is notified or otherwise learns that a Member has had an ED visit or is hospitalized for an overdose or Substance Use Disorder, the MCO's Care Coordination staff shall actively participate and assist hospital staff in the development of a written discharge plan.

4.11.6.18.2 The MCO shall ensure that the final discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of Members discharged.

4.11.6.18.3 The MCO shall ensure that the discharge progress note shall be provided to any treatment Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.11.6.18.3.1. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.11.6.18.4 It is the expectation of DHHS that Members treated in the ED or inpatient setting for an overdose are not to be released to the community without outreach from the MCO or provided with referrals for an evaluation and treatment.

4.11.6.18.5 The MCO shall track all Members discharged into the community who do not receive MCO contact (including outreach or a referral to a Substance Use Disorder program and/or Provider).

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4.11.6.18.6 The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from the ED to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.11.6.18.7 At least ninety-five percent (95%) of Members discharged shall have been attempted to be contacted within three (3) business days.

4.11.6.18.8 For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the treatment Provider and request that the treatment Provider make contact with the Member within twenty-four (24) hours.

4.11.6.18.9 The MCO shall ensure an appointment for treatment other than evaluation with a Substance Use Disorder program and/or Provider for the Member is scheduled prior to discharge when possible and that transportation has been arranged for the appointment. Such appointments shall occur within seven (7) calendar days after discharge.

4.11.6.18.10 In accordance with 42 CFR Part 2, the MCO shall work with DHHS during regularly scheduled meetings to review cases of Members that have been seen for more than three (3) overdose events within a thirty (30) calendar day period or those that have had a difficulty engaging in treatment services following referral and Care Coordination provided by the MCO.

4.11.6.18.11 The MCO shall also review Member cases with the applicable Substance Use Disorder program and/or Provider to promote strategies for reducing overdoses and increase engagement in treatment services.

4.12 Quality Management

4.12.1 General Provisions

4.12.1.1 The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

4.12.1.2 [Amendment #7:] The MCO shall work in collaboration with DHHS, Members and Providers to actively improve the quality of

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care provided to Members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement.

4.12.1.2.1 [Amendment #7:] The MCO shall conduct reviews and audits of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP), as described in separate guidance.

4.12.1.3 The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate in the MCO's quality improvement activities.

4.12.1.4 The MCO shall support and comply with the most current version of the Quality Strategy for the MCM program.

4.12.1.5 The MCO shall approach all clinical and non-clinical aspects of QAPI based on principles of CQI/Total Quality Management and shall:

4.12.1.5.1 Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

4.12.1.5.2 Foster data-driven decision-making;

4.12.1.5.3 Solicit Member and Provider input on the prioritization and strategies for QAPI activities;

4.12.1.5.4 Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and Member and Provider satisfaction;

4.12.1.5.5 Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

4.12.1.5.6 Support re-measurement of effectiveness, health outcomes improvement and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

4.12.2 Health Plan Accreditation

4.12.2.1 The MCO shall achieve health plan accreditation from the NCQA, including the NCQA Medicaid Module.

4.12.2.2 If the MCO participated in the MCM program prior to the Program Start Date, the MCO shall maintain its health plan accreditation status throughout the period of the Agreement, and

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complete the NCQA Medicaid Module within eighteen (18) months of the Program Start Date.

4.12.2.3 If the MCO is newly participating in the MCM program, the MCO shall achieve health plan accreditation from NCQA, including the Medicaid Module, within eighteen (18) months of the Program Start Date.

4.12.2.4 To demonstrate its progress toward meeting this requirement, the newly participating MCO shall complete the following milestones:

4.12.2.4.1 Within sixty (60) calendar days of the Program Start Date, the MCO shall notify DHHS of the initiation of the process to obtain NCQA Health Plan Accreditation; and

4.12.2.4.2 Within thirty (30) calendar days of the date of the NCQA survey on-site review, the MCO shall notify DHHS of the date of the scheduled on-site review.

4.12.2.5 The MCO shall inform DHHS of whether it has been accredited by any private independent accrediting entity, in addition to NCQA Health Plan Accreditation.

4.12.2.6 The MCO shall authorize NCQA, and any other entity from which it has received or is attempting to receive accreditation, to provide a copy of its most recent accreditation review to DHHS, including [42 CFR 438.332(a)]:

4.12.2.6.1 Accreditation status, survey type, and level (as applicable);

4.12.2.6.2 Accreditation results, including recommended actions or improvements, CAPs, and summaries of findings; and

4.12.2.6.3 Expiration date of the accreditation. [42 CFR 438.332(b)(1)-(3)]

4.12.2.7 To avoid duplication of mandatory activities with accreditation reviews, DHHS may indicate in its quality strategy the accreditation review standards that are comparable to the standards established through federal EQR protocols and that DHHS shall consider met on the basis of the MCO's achievement of NCQA accreditation. [42 CFR 438.360]

4.12.2.8 An MCO going through an NCQA renewal survey shall complete the full Accreditation review of all NCQA Accreditation Standards.

4.12.2.9 During the renewal survey, the MCO shall:

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4.12.2.9.1 Request from NCQA the full review of all NCQA Accreditation Standards and cannot participate in the NCQA renewal survey option that allows attestation for certain requirements; and

4.12.2.9.2 Submit to DHHS a written confirmation from NCQA stating that the renewal survey for the MCO will be for all NCQA Accreditation Standards without attestation.

4.12.3 Quality Assessment and Performance Improvement Program

4.12.3.1 The MCO shall have an ongoing comprehensive QAPI program for the services it furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)].

4.12.3.2 The MCO's QAPI program shall be documented in writing (in the form of the "QAPI Plan"), approved by the MCO's governing body, and submitted to DHHS for its review annually.

4.12.3.3 In accordance with Exhibit O, the QAPI Plan shall contain, at a minimum, the following elements:

4.12.3.3.1 A description of the MCO's organization-wide QAPI program structure;

4.12.3.3.2 The MCO's annual goals and objectives for all quality activities, including but not limited to:

4.12.3.3.2.1. DHHS-required PIPs,

4.12.3.3.2.2. DHHS-required quality performance data,

4.12.3.3.2.3. DHHS-required quality reports, and

4.12.3.3.2.4. Implementation of EQRO recommendations from annual technical reports;

4.12.3.3.3 Mechanisms to detect both underutilization and overutilization of services [42 CFR 438.330(b)(3)];

4.12.3.3.4 Mechanisms to assess the quality and appropriateness of care for Members with Special Health Care Needs (as defined by DHHS in the quality strategy) [42 CFR 438.330(b)(4)] in order to identify any Ongoing Special Conditions of a Member that require a course of treatment or regular care monitoring;

4.12.3.3.5 Mechanisms to assess and address disparities in the quality of, and access to, health care, based on age, race, ethnicity, sex, primary language, and disability status (defined as whether the

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individual qualified for Medicaid on the basis of a disability) [42 CFR 438.340(b)(6)]; and

4.12.3.3.6 The MCO's systematic and ongoing process for monitoring, evaluation and improvement of the quality and appropriateness of Behavioral Health Services provided to Members.

4.12.3.4 The MCO shall maintain a well-defined QAPI program structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the MCO shall ensure that the QAPI program structure:

4.12.3.4.1 Is organization-wide, with clear lines of accountability within the organization;

4.12.3.4.2 Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, clinicians, and non-clinicians;

4.12.3.4.3 Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

4.12.3.4.4 Evaluates the effectiveness of clinical and non-clinical initiatives.

4.12.3.5 If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the MCO shall maintain detailed files documenting work performed by the Subcontractor. The file shall be available for review by DHHS or its designee upon request, and a summary of any functions that have been delegated to Subcontractor(s) shall be indicated within the MCO's QAPI Plan submitted to DHHS annually.

4.12.3.6 Additional detail regarding the elements of the QAPI program and the format in which it should be submitted to DHHS is provided in Exhibit O.

4.12.3.7 Performance Improvement Projects

4.12.3.7.1 The MCO shall conduct any and all PIPs required by CMS. [42 CFR 438.330(a)(2)]

4.12.3.7.2 [Amendment #5:] Throughout the five-year contract period, Annually, the MCO shall conduct at least three (3) clinical PIPs that meet the following criteria [42 CFR 438.330 (d)(1)]:

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4.12.3.7.2.1. [Amendment #8:] At least one (1) clinical PIP shall have a focus on the Department's objectives outlined in the NH MCM Quality Strategy reducing Psychiatric Boarding in the ED for Medicaid enrollees (regardless of whether they are Medicaid-Medicare dual individuals), as defined in Section 4.11.5 (Mental Health);

4.12.3.7.2.2. At least one (1) clinical PIP shall have a focus on Substance Use Disorder, as defined in Section 4.11.6 (Substance Use Disorder);

4.12.3.7.2.3. At least (1) clinical PIP shall focus on improving quality performance in an area that the MCO performed lower than the fiftieth (50th) percentile nationally, as documented in the most recent EQRO technical report or as otherwise indicated by DHHS.

4.12.3.7.2.4. [Amendment #5:] If the MCO's individual experience is not reflected in the most recent EQRO technical report, the MCO shall incorporate a PIP in an area that the MCOs participating in the MCM program at the time of the most recent EQRO technical report performed below the ~~fiftieth (50th)~~ seventy-fifth (75th) percentile.

4.12.3.7.2.5. [Amendment #5:] Should no quality measure have a lower than ~~fiftieth (50th)~~ seventy-fifth (75th) percentile performance, the MCO shall focus the PIP on one (1) of the areas for which its performance (or, in the event the MCO is not represented in the most recent report, the other MCOs' collective performance) was lowest.

4.12.3.7.3 [Amendment #7:] Throughout the five-year contract ~~Annually~~, the MCO shall conduct at least one (1) non-clinical PIP, which shall be related to one (1) of the following topic areas and approved by DHHS:

4.12.3.7.3.1. Addressing social determinants of health;

4.12.3.7.3.2. Integrating physical and behavioral health.

4.12.3.7.4 The non-clinical PIP may include clinical components, but shall have a primary focus on non-clinical outcomes.

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4.12.3.7.5 The MCO shall ensure that each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction [42 CFR 438.330(d)(2)], and shall include the following elements:

4.12.3.7.5.1. Measurement(s) of performance using objective quality indicators [42 CFR 438.330(d)(2)(i)];

4.12.3.7.5.2. Implementation of interventions to achieve improvement in the access to and quality of care [42 CFR 438.330(d)(2)(ii)];

4.12.3.7.5.3. Evaluation of the effectiveness of the interventions based on the performance measures used as objective quality indicators [42 CFR 438.330(d)(2)(iii)]; and

4.12.3.7.5.4. Planning and initiation of activities for increasing or sustaining improvement [42 CFR 438.330(d)(2)(iv)].

4.12.3.7.6 Each PIP shall be approved by DHHS and shall be completed in a reasonable time period so as to generally permit information on the success of PIPs in the aggregate to produce new information on quality of care every year.

4.12.3.7.7 In accordance with Exhibit O, the MCO shall include in its QAPI Plan, to be submitted to DHHS annually, the status and results of each PIP conducted in the preceding twelve (12) months and any changes it plans to make to PIPs or other MCO processes in the coming years based on these results or other findings [42 CFR 438.330(d)(1) and (3)].

4.12.3.7.8 [Amendment #3:] At the sole discretion of DHHS, the PIPs may be delayed in the event of a public health emergency.

4.12.3.8 Member Experience of Care Survey

4.12.3.8.1 The MCO shall be responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on an annual basis, and as required by NCQA for Medicaid health plan accreditation for both adults and children, including:

4.12.3.8.1.1. CAHPS Health Plan Survey 5.0H, Adult Version or later version as specified by DHHS;

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4.12.3.8.1.2. CAHPS Health Plan Survey 5.0H, Child Version with Children with Chronic Conditions Supplement or later version as specified by DHHS.

4.12.3.8.2 Each CAHPS survey administered by the MCO shall include up to twelve (12) other supplemental questions for each survey as defined by DHHS and indicated in Exhibit O. Supplemental questions, including the number, are subject to NCQA approval.

4.12.3.8.3 The MCO shall obtain DHHS approval of instruments prior to fielding the CAHPS surveys.

4.12.3.9 Quality Measures

4.12.3.9.1 The MCO shall report the following quality measure sets annually according to the current industry/regulatory standard definitions, in accordance with Exhibit O [42 CFR 438.330(b)(2); 42 CFR 438.330(c)(1) and (2); 42 CFR 438.330(a)(2)]:

4.12.3.9.1.1. CMS Child Core Set of Health Care Quality Measures for Medicaid and CHIP, as specified by DHHS;

4.12.3.9.1.2. CMS Adult Core Set of Health Care Quality Measures for Medicaid, as specified by DHHS;

4.12.3.9.1.3. [Amendment #6:] NCQA Medicaid Accreditation measures, including race and ethnicity stratification, which shall be generated without NCQA Allowable Adjustments and validated by submission to NCQA;

4.12.3.9.1.3.1 [Amendment #7] The MCO shall include supplemental data in HEDIS measures identified in Exhibit O for NCQA Accreditation and reporting through Interactive Data Submission System.

4.12.3.9.1.3.2 [Amendment #8:] The MCO shall report Member level data for audited HEDIS measures as identified in Exhibit O.

4.12.3.9.1.4. All available CAHPS measures and sections and additional supplemental questions defined by DHHS;

4.12.3.9.1.5. Any CMS-mandated measures [42 CFR 438.330(c)(1)(i)];

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4.12.3.9.1.6. Select measures to monitor MCO Member and Provider operational quality and Care Coordination efforts;

4.12.3.9.1.7. [Amendment #7:] Select measures specified by DHHS as priority measures for use in assessing and addressing local challenges to high-quality care and access; and

4.12.3.9.1.8. [Amendment #7:] Measures indicated by DHHS as a requirement for fulfilling CMS waiver requirements; and

4.12.3.9.1.9. [Amendment #7] Measures indicated by DHHS as a requirement for the CMS Managed Care Program Annual Report [42 CFR 438.66(e)].

4.12.3.9.2 Consistent with State and federal law, and utilizing all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information, the MCO shall collaborate in data collection with the Integrated Delivery Networks for clinical data collected for quality and performance measures common between the MCM program and the DSRIP program to reduce duplication of effort in collection of data.

4.12.3.9.3 The MCO shall report all quality measures in accordance with Exhibit O, regardless of whether the MCO has achieved accreditation from NCQA.

4.12.3.9.4 The MCO shall submit all quality measures in the formats and schedule in Exhibit O or otherwise identified by DHHS. This includes , as determined by DHHS:

4.12.3.9.4.1. Gain access to and utilize the NH Medicaid Quality Information System, including participating in any DHHS-required training necessary;

4.12.3.9.4.2. Attend all meetings with the relevant MCO subject matter experts to discuss specifications for data indicated in Exhibit O; and

4.12.3.9.4.3. Communicate and distribute all specifications and templates provided by DHHS for measures in Exhibit O to all MCO subject matter experts involved in the production of data in Exhibit O.

4.12.3.9.5 If additional measures are added to the NCQA or CMS measure sets, the MCO shall include any such new measures in its reports to DHHS.

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4.12.3.9.6 For measures that are no longer part of the measure sets, DHHS may, at its option, continue to require those measures; any changes to MCO quality measure reporting requirements shall be communicated to MCOs and documented within a format similar to Exhibit O.

4.12.3.9.7 DHHS shall provide the MCO with ninety (90) calendar days of notice of any additions or modifications to the measures and quality measure specifications.

4.12.3.9.8 At such time as DHHS provides access to Medicare data sets to the MCO, the MCO shall integrate expanded Medicare data sets into its QAPI Plan and Care Coordination and Quality Programs, and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual Members. The MCO shall:

4.12.3.9.8.1. Collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes and psycho-social outcomes resulting from Care Coordination of the dual Members;

4.12.3.9.8.2. Include Medicare data in DHHS quality reporting; and

4.12.3.9.8.3. Sign data use Agreements and submit data management plans, as required by CMS.

4.12.3.9.9 For failure to submit required reports and quality data to DHHS, NCQA, the EQRO, and/or other DHHS-identified entities, the MCO shall be subject to liquidated damages as further described in Section 5.5.2 (Liquidated Damages).

4.12.4 Evaluation

4.12.4.1 DHHS shall, at a minimum, collect the following information, and the information specified throughout the Agreement and within Exhibit O, in order to improve the performance of the MCM program [42 CFR 438.66(c)(6)-(8)]:

4.12.4.1.1 Performance on required quality measures; and

4.12.4.1.2 The MCO's QAPI Plan.

4.12.4.2 Starting in the second year of the Term of this Agreement, the MCO shall include in its QAPI Plan a detailed report of the MCO's performance against its QAPI Plan throughout the duration of the

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preceding twelve (12) months, and how its development of the proposed, updated QAPI plan has taken those results into account. The report shall include detailed information related to:

4.12.4.2.1 Completed and ongoing quality management activities, including all delegated functions;

4.12.4.2.2 Performance trends on QAPI measures to assess performance in quality of care and quality of service (QOS) for all activities identified in the QAPI Plan;

4.12.4.2.3 An analysis of whether there have been any demonstrated improvements in the quality of care or service for all activities identified in the QAPI Plan;

4.12.4.2.4 An analysis of actions taken by the MCO based on MCO specific recommendations identified by the EQRO's Technical Report and other Quality Studies; and

4.12.4.2.5 An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement.

4.12.4.3 The annual evaluation report, developed in accordance with Exhibit O, shall be reviewed and approved by the MCO's governing body and submitted to DHHS for review [42 CFR 438.330(e)(2)].

4.12.4.4 The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, Members, and appropriate MCO staff, as well as for posting on the web.

4.12.4.5 In accordance with Exhibit O, the MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to DHHS and reviewed by the appropriate individuals within the organization.

4.12.5 Accountability for Quality Improvement

4.12.5.1 External Quality Review

4.12.5.1.1 The MCO shall collaborate and cooperate fully with DHHS's EQRO in the conducting of CMS EQR activities to identify opportunities for MCO improvement [42 CFR 438.358].

4.12.5.1.2 Annually, the MCO shall undergo external independent reviews of the quality, timeliness, and access to services for Members [42 CFR 438.350].

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4.12.5.1.3 To facilitate this process, the MCO shall supply information, including but not limited to:

- 4.12.5.1.3.1. Claims data,
- 4.12.5.1.3.2. Medical records,
- 4.12.5.1.3.3. Operational process details, and
- 4.12.5.1.3.4. Source code used to calculate performance measures to the EQRO as specified by DHHS.

4.12.5.2 Auto-Assignment Algorithm

4.12.5.2.1 As indicated in Section 4.3.6 (Auto-Assignment), the auto-assignment algorithm shall, over time, reward high-performing MCOs that offer high-quality, accessible care to its Members.

4.12.5.2.2 [Amendment #5:] The measures used to determine auto-assignment ~~shall not be limited to alignment shall be aligned~~ with the priority measures assigned to the program MCM Withhold and Incentive Program MCO withhold program, as determined by DHHS.

4.12.5.3 Quality Performance Withhold

4.12.5.3.1 [Amendment #5:] As described in Section 5.4 (MCM Withhold and Incentive Program), the MCM program incorporates a withhold and incentive arrangement; the MCO's performance in the program may be assessed on the basis of the MCO's quality performance, as determined by DHHS and indicated to the MCO in annual periodic guidance.

4.12.5.3.2 [Amendment #5:] Intentionally left blank. ~~Key areas of DHHS focus in the selection of measures shall include, but are not limited to:~~

4.12.5.3.2.1. [Amendment #5:] Intentionally left blank. ~~Utilization measures, including appropriate use of the ED, reduction in preventable admissions, and/or 30-day hospital readmission for all causes;~~

4.12.5.3.2.2. [Amendment #5:] Intentionally left blank. ~~Measures related to the timeliness of prenatal and postpartum care and in improved outcomes related to NAS births;~~

4.12.5.3.2.3. [Amendment #5:] Intentionally left blank. ~~Successful integration of physical and behavioral health,~~

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~~including timeliness of a follow-up after a mental illness or Substance Use Disorder inpatient or residential admission;~~

4.12.5.3.2.4. [Amendment #5:] Intentionally left blank.
~~Reduction in polypharmacy resulting in drug interaction harm; and~~

4.12.5.3.2.5. [Amendment #5:] Intentionally left blank.
~~Certain clinical and non-clinical quality measures for which there is ample opportunity for improved MCO performance.~~

4.13 Network Management

4.13.1 Network Requirements

4.13.1.1 The MCO shall maintain and monitor a network of appropriate Participating Providers that is:

4.13.1.1.1 Supported by written agreements; and

4.13.1.1.2 Sufficient to provide adequate access to all services covered under this Agreement for all Members, including those with LEP or disabilities. [42 CFR 438.206(b)(1)]

4.13.1.2 In developing its network, the MCO's Provider selection policies and procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

4.13.1.3 [Amendment #8:] The MCO shall not employ or contract with Providers excluded from participation in federal health care programs [42 CFR 438.214(d)(1)]; 42 CFR 455.101; Section 1932(d)(5) of the Act.

4.13.1.4 The MCO shall not employ or contract with Providers who fail to provide Equal Access to services.

4.13.1.5 The MCO shall ensure its Participating Providers and Subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement. [42 CFR 438.230]

4.13.1.6 All Participating Providers shall be licensed and or certified in accordance with the laws of NH and not be under sanction or exclusion from any Medicare or Medicaid program. Participating Providers shall have a NH Medicaid identification number and unique

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National Provider Identifier (NPI) for every Provider type in accordance with 45 CFR 162, Subpart D.

4.13.1.7 The MCO shall provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Medical Conditions.

4.13.1.8 The MCO shall make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Agreement can be furnished promptly and without compromising the quality of care. [42 CFR 438.3(q)(1); 42 CFR 438.3(q)(3)]

4.13.1.9 The MCO shall permit Non-Participating IHCPs to refer an American Indian/Alaskan Native Member to a Participating Provider. [42 CFR 438.14(b)(6)]

4.13.1.10 The MCO shall implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Participating Providers were received by Members and the application of such verification processes on a regular basis. [42 CFR 438.608(a)(5)]

4.13.1.11 [Amendment #4.] When contracting with DME Providers, the MCO shall contract with and have in its network all Willing Providers in the state.

4.13.2 Provider Enrollment

4.13.2.1 The MCO shall ensure that its Participating Providers are enrolled with NH Medicaid.

4.13.2.2 The MCO shall prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by DHHS for determination of the MCO's network adequacy.

4.13.2.2.1 The report shall identify fully credentialed and contracted Providers, and prospective Participating Providers.

4.13.2.2.2 Prospective Participating Providers shall have executed letters of intent to contract with the MCO.

4.13.2.2.3 The MCO shall confirm its provider network with DHHS and post to its website no later than thirty (30) calendar days prior to the Member enrollment period.

4.13.2.3 The MCO shall not discriminate relative to the participation, reimbursement, or indemnification of any Provider who

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is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

4.13.2.4 If the MCO declines to include individual Provider or Provider groups in its network, the MCO shall give the affected Providers written notice of the reason for its decision. [42 CFR 438.12(a)(1); 42 CFR 438.214(c)].

4.13.2.5 The requirements in 42 CFR 438.12(a) shall not be construed to:

4.13.2.5.1 Require the MCO to contract with Providers beyond the number necessary to meet the needs of its Members;

4.13.2.5.2 Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

4.13.2.5.3 Preclude the MCO from establishing measures that are designed to maintain QOS and control costs and is consistent with its responsibilities to Members. [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)-(3)]

4.13.2.6 The MCO shall ensure that Participating Providers are enrolled with DHHS Medicaid as Medicaid Providers consistent with Provider disclosure, screening and enrollment requirements. [42 CFR 438.608(b); 42 CFR 455.100-106; 42 CFR 455.400 – 470]

4.13.3 Provider Screening, Credentialing and Re-Credentialing

4.13.3.1 DHHS shall screen and enroll, and periodically revalidate all MCO Participating Providers as Medicaid Providers. [42 CFR 438.602(b)(1)].

4.13.3.2 The MCO shall rely on DHHS's NH Medicaid providers' affirmative screening in accordance with federal requirements and the current NCQA Standards and Guidelines for the credentialing and re-credentialing of licensed independent Providers and Provider groups with whom it contracts or employs and who fall within its scope of authority and action. [42 CFR 455.410; 42 CFR 438.206)(b)(6)]

4.13.3.3 The MCO shall utilize a universal provider datasource, at no charge to the provider, to reduce administrative requirements and streamline data collection during the credentialing and re-credentialing process.

4.13.3.4 The MCO shall demonstrate that its Participating Providers are credentialed, and shall comply with any additional Provider selection requirements established by DHHS. [42 CFR

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438.12(a)(2); 42 CFR 438.214(b)(1); 42 CFR 438.214(c); 42 CFR 438.214(e); 42 CFR 438.206(b)(6)]

4.13.3.5 The MCO's Provider selection policies and procedures shall include a documented process for credentialing and re-credentialing Providers who have signed contracts with the MCO. [42 CFR 438.214(b)]

4.13.3.6 The MCO shall submit for DHHS review during the Readiness Review period, policies and procedures for onboarding Participating Providers, which shall include its subcontracted entity's policies and procedures.

4.13.3.7 For Providers not currently enrolled with NH Medicaid, the MCO shall:

4.13.3.7.1 Make reasonable efforts to streamline the credentialing process in collaboration with DHHS;

4.13.3.7.2 Conduct outreach to prospective Participating Providers within ten (10) business days after the MCO receives notice of the Providers' desire to enroll with the MCO;

4.13.3.7.3 Concurrently work through MCO and DHHS contracting and credentialing processes with Providers in an effort to expedite the Providers' network status; and

4.13.3.7.4 Educate prospective Participating Providers, on optional Member treatment and payment options while credentialing is underway, including:

4.13.3.7.4.1. Authorization of out-of-network services;

4.13.3.7.4.2. Single case agreements for an individual Member; and

4.13.3.7.4.3. If agreed upon by the prospective Participating Provider, an opportunity for the Provider to accept a level of risk to receive payment after affirmative credentialing is completed in exchange for the prospective Participating Provider's compliance with network requirements and practices.

4.13.3.8 The MCO shall process credentialing applications from all types of Providers within prescribed timeframes as follows:

4.13.3.8.1 For PCPs, within thirty (30) calendar days of receipt of clean and complete credentialing applications; and

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4.13.3.8.2 For specialty care Providers, within forty-five (45) calendar days of receipt of clean and complete credentialing applications;

4.13.3.8.3 For any Provider submitting new or missing information for its credentialing application, the MCO shall act upon the new or updated information within ten (10) business days.

4.13.3.9 The start time for the approval process begins when the MCO has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status.

4.13.3.10 A "clean and complete" application is an application that is signed and appropriately dated by the Provider, and includes:

4.13.3.10.1 Evidence of the Provider's NH Medicaid ID; and

4.13.3.10.2 Other applicable information to support the Provider application, including Provider explanations related to quality and clinical competence satisfactory to the MCO.

4.13.3.11 In the event the MCO does not process a Provider's clean and complete credentialing application within the timeframes set forth in this Section 4.13.3 of the Agreement, the MCO shall pay the Provider retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application, depending on the prescribed timeframe for the Provider type as defined in 4.13.3.8 above.

4.13.3.12 For each day a clean and complete application is delayed beyond the prescribed timeframes in this Agreement as determined by periodic audit of the MCO's Provider enrollment records by DHHS or its designee, the MCO shall be fined in accordance with Exhibit N (Liquidated Damages Matrix).

4.13.3.13 Nothing in this Agreement shall be construed to require the MCO to select a health care professional as a Participating Provider solely because the health care professional meets the NH Medicaid screening and credentialing verification standards, or to prevent an MCO from utilizing additional criteria in selecting the health care professionals with whom it contracts.

4.13.4 Provider Engagement

4.13.4.1 Provider Support Services

4.13.4.1.1 The MCO shall develop and make available Provider support services which include, at a minimum:

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4.13.4.1.1.1. A website with information and a dedicated contact number to assist and support Providers who are interested in becoming Participating Providers;

4.13.4.1.1.2. A dedicated contact number to MCO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday and 9:00 a.m. to 12:00 p.m. on Saturday for the purposes of answering questions related to contracting, billing and service provision.

4.13.4.1.1.3. Ability for Providers to contact the MCO regarding contracting, billing, and service provisions;

4.13.4.1.1.4. Training specific to integration of physical and behavioral health, person-centered Care Management, social determinants of health, and quality;

4.13.4.1.1.5. Training curriculum, to be developed, in coordination with DHHS, that addresses clinical components necessary to meet the needs of Children with Special Health Care Needs. Examples of clinical topics shall include: federal requirements for EPSDT; unique needs of Children with Special Health Care Needs; family-driven, youth-guided, person-centered treatment planning and service provisions; impact of adverse childhood experiences; utilization of evidence-based practices; trauma-informed care; Recovery and resilience principles; and the value of person-centered Care Management that includes meaningful engagement of families/caregivers;

4.13.4.1.1.6. Training on billing and required documentation;

4.13.4.1.1.7. Assistance and/or guidance on identified opportunities for quality improvement;

4.13.4.1.1.8. Training to Providers in supporting and assisting Members in grievances and appeals, as noted in Section 4.5.1 (General Requirements); and

4.13.4.1.1.9. Training to Providers in MCO claims submittal through the MCO Provider portal.

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4.13.4.1.2 The MCO shall establish and maintain a Provider services function to respond timely and adequately to Provider questions, comments, and inquiries.

4.13.4.1.3 As part of this function, the MCO shall operate a toll-free telephone line (Provider service line) from, at minimum, eight (8:00) am to five (5:00) pm EST, Monday through Friday, with the exception of DHHS-approved holidays. The Provider call center shall meet the following minimum standards, which may be modified by DHHS as necessary:

4.13.4.1.3.1. Call abandonment rate: fewer than five percent (5%) of all calls shall be abandoned;

4.13.4.1.3.2. Average speed of answer: eighty percent (80%) of all calls shall be answered with live voice within thirty (30) seconds;

4.13.4.1.3.3. Average speed of voicemail response: ninety percent (90%) of voicemail messages shall be responded to no later than the next business day (defined as Monday through Friday, with the exception of DHHS-approved holidays).

4.13.4.1.4 The MCO shall ensure that, after regular business hours, the Provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a Member.

4.13.4.1.5 The MCO shall have a process in place to handle after-hours inquiries from Providers seeking a service authorization for a Member with an urgent or emergency medical or behavioral health condition.

4.13.4.1.6 The MCO shall track the use of State-selected and nationally recognized clinical Practice Guidelines for Children with Special Health Care Needs.

4.13.4.1.7 DHHS may provide additional guidelines to MCOs pertaining to evidence-based practices related to the following: Trauma-Focused Cognitive Behavioral Therapy; Trauma Informed Child-Parent Psychotherapy; Multi-systemic Therapy; Functional Family Therapy; Multi-Dimensional Treatment Foster Care; DBT; Multidimensional Family Therapy; Adolescent Community Reinforcement; and Assertive Continuing Care.

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4.13.4.1.8 The MCO shall track and trend Provider inquiries, complaints and requests for information and take systemic action as necessary and appropriate pursuant to Exhibit O.

4.13.4.2 Provider Advisory Board

4.13.4.2.1 [Amendment #8:] The MCO shall develop and facilitate an active Provider Advisory Board that is composed of a broad spectrum of Provider types. Provider representation on the Provider Advisory Board shall draw from and be reflective of Member needs and should ensure accurate and timely feedback on the MCM program, and shall include representation from at least one (1) FQHC, at least one (1) CMH Program, and at least one (1) Local Care Management Network provider, as applicable. ~~Integrated Delivery Network (IDN).~~

4.13.4.2.2 The Provider Advisory Board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the Provider Advisory Board meetings shall be provided to DHHS upon request.

4.13.5 Provider Contract Requirements

4.13.5.1 General Provisions

4.13.5.1.1 The MCO's agreement with health care Providers shall:

4.13.5.1.1.1. Be in writing,

4.13.5.1.1.2. Be in compliance with applicable State and federal laws and regulations, and

4.13.5.1.1.3. Include the requirements in this Agreement.

4.13.5.1.2 The MCO shall submit all model Provider contracts to DHHS for review before execution of the Provider contracts with NH Medicaid Providers.

4.13.5.1.3 The MCO shall re-submit the model Provider contracts any time it makes substantive modifications.

4.13.5.1.4 DHHS retains the right to reject or require changes to any Provider contract.

4.13.5.1.5 In all contracts with Participating Providers, the MCO shall comply with requirements in 42 CFR 438.214 and RSA 420-J:4, which includes selection and retention of Participating Providers, credentialing and re-credentialing requirements, and non-discrimination.

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4.13.5.1.6 In all contracts with Participating Providers, the MCO shall follow a documented process for credentialing and re-credentialing of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(b)(2)]

4.13.5.1.7 The MCO's Participating Providers shall not discriminate against eligible Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, the ADA of 1990, 42 U.S.C. Section 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

4.13.5.1.8 The MCO shall require Participating Providers and Subcontractors to not discriminate against eligible persons or Members on the basis of their health or behavioral health history, health or behavioral health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4.13.5.1.9 The MCO shall keep participating physicians and other Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

4.13.5.1.10 The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.14 (Alternative Payment Models).

4.13.5.1.11 The MCO may execute Participating Provider agreements, pending the outcome of screening and enrollment in NH Medicaid, of up to one hundred and twenty (120) calendar days duration but shall terminate a Participating Provider immediately upon notification from DHHS that the Participating Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without enrollment of the Provider, and notify affected Members. [42 CFR 438.602(b)(2)]

4.13.5.1.12 The MCO shall maintain a Provider relations presence in NH, as approved by DHHS.

4.13.5.1.13 The MCO shall prepare and issue Provider Manual(s) upon request to all newly contracted and credentialed Providers and

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all Participating Providers, including any necessary specialty manuals (e.g., behavioral health).

4.13.5.1.13.1. The Provider manual shall be available and easily accessible on the web and updated no less than annually.

4.13.5.1.14 The MCO shall provide training to all Participating Providers and their staff regarding the requirements of this Agreement, including the grievance and appeal system.

4.13.5.1.14.1. The MCO's Provider training shall be completed within thirty (30) calendar days of entering into a contract with a Provider.

4.13.5.1.14.2. The MCO shall provide ongoing training to new and existing Providers as required by the MCO, or as required by DHHS.

4.13.5.1.15 Provider materials shall comply with State and federal laws and DHHS and NHID requirements.

4.13.5.1.16 The MCO shall submit any Provider Manual(s) and Provider training materials to DHHS for review during the Readiness Review period and sixty (60) calendar days prior to any substantive revisions.

4.13.5.1.17 Any revisions required by DHHS shall be provided to the MCO within thirty (30) calendar days.

4.13.5.1.18 The MCO Provider Manual shall consist of, at a minimum:

4.13.5.1.18.1. A description of the MCO's enrollment and credentialing process;

4.13.5.1.18.2. How to access MCO Provider relations assistance;

4.13.5.1.18.3. A description of the MCO's medical management and Case Management programs;

4.13.5.1.18.4. Detail on the MCO's Prior Authorization processes;

4.13.5.1.18.5. A description of the Covered Services and Benefits for Members, including EPSDT and pharmacy;

4.13.5.1.18.6. A description of Emergency Services coverage;

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4.13.5.1.18.7. Member parity;

4.13.5.1.18.8. The MCO Payment policies and processes; and

4.13.5.1.18.9. The MCO Member and Provider Grievance System.

4.13.5.1.19 The MCO shall require that Providers not bill Members for Covered Services any amount greater than the Medicaid cost-sharing owed by the Member (i.e., no balance billing by Providers). [Section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230(c)(1)-(2)]

4.13.5.1.20 In all contracts with Participating Providers, the MCO shall require Participating Providers to remain neutral when assisting potential Members and Members with enrollment decisions.

4.13.5.2 Compliance with MCO Policies and Procedures

4.13.5.2.1 The MCO shall require Participating Providers to comply with all MCO policies and procedures, including without limitation:

4.13.5.2.1.1. The MCO's DRA policy;

4.13.5.2.1.2. The Provider Manual;

4.13.5.2.1.3. The MCO's Compliance Program;

4.13.5.2.1.4. The MCO's Grievance and Appeals and Provider Appeal Processes;

4.13.5.2.1.5. Clean Claims and Prompt Payment requirements;

4.13.5.2.1.6. ADA requirements;

4.13.5.2.1.7. Clinical Practice Guidelines; and

4.13.5.2.1.8. Prior Authorization requirements.

4.13.5.3 The MCO shall inform Participating Providers, at the time they enter into a contract with the MCO, about the following requirements, as described in Section 4.5 (Member Grievances and Appeals), of:

4.13.5.3.1 Member grievance, appeal, and fair hearing procedures and timeframes;

4.13.5.3.2 The Member's right to file grievances and appeals and the requirements and timeframe for filing;

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4.13.5.3.3 The availability of assistance to the Member with filing grievances and appeals; [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(A)-(C)]

4.13.5.3.4 The Member's right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)]

4.13.5.3.5 The Member's right to request continuation of benefits that the MCO seeks to reduce or terminate during an appeal of State fair hearing filing, if filed within the permissible timeframes, although the Member may be liable for the cost of any continued benefits while the appeal or State fair hearing is pending if the final decision is adverse to the Member. [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(E)]

4.13.5.4 Member Hold Harmless

4.13.5.4.1 The Provider shall agree to hold the Member harmless for the costs of Medically Necessary Covered Services except for applicable cost sharing and patient liability amounts indicated by DHHS in this Agreement [RSA 420-J:8.I.(a)]

4.13.5.5 Requirement to Return Overpayment

4.13.5.5.1 The Provider shall comply with the Affordable Care Act and the MCO's policies and procedures that require the Provider to report and return any Overpayments identified within sixty (60) calendar days from the date the Overpayment is identified, and to notify the MCO in writing of the reason for the Overpayment. [42 CFR 438.608(d)(2)]

4.13.5.5.2 Overpayments that are not returned within sixty (60) calendar days from the date the Overpayment was identified may be a violation of State or federal law.

4.13.5.6 Background Screening

4.13.5.6.1 The Provider shall screen its staff prior to contracting with the MCO and monthly thereafter against the Exclusion Lists.

4.13.5.6.1.1. In the event the Provider identifies that any of its staff is listed on any of the Exclusion Lists, the Provider shall notify the MCO within three (3) business days of learning of that such staff Member is listed on any of the Exclusion Lists and immediately remove such person from providing services under the agreement with the MCO.

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4.13.5.7 Books and Records Access

4.13.5.7.1 The Provider shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the Members as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements.

4.13.5.7.2 The Provider shall make available, for the purposes of an audit, evaluation, or inspection by the MCO, DHHS, MFCU, DOJ, the OIG, and the Comptroller General or their respective designees:

4.13.5.7.3 Its premises,

4.13.5.7.4 Physical facilities,

4.13.5.7.5 Equipment,

4.13.5.7.6 Books,

4.13.5.7.7 Records,

4.13.5.7.8 Contracts, and

4.13.5.7.9 Computer, or other electronic systems relating to its Medicaid Members.

4.13.5.7.10 These records, books, documents, etc., shall be available for any authorized State or federal agency, including but not limited to the MCO, DHHS, MFCU, DOJ, and the OIG or their respective designees, ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

4.13.5.8 Continuity of Care

4.13.5.8.1 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth by DHHS and included in the DHHS model Member Handbook.

4.13.5.9 Anti-Gag Clause

4.13.5.9.1 The MCO shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient:

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4.13.5.9.1.1. For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

4.13.5.9.1.2. For any information the Member needs in order to decide among all relevant treatment options;

4.13.5.9.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

4.13.5.9.1.4. For the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. [Section 1923(b)(3)(D) of the Social Security Act; 42 CFR 438.102(a)(1)(i)-(iv); SMDL 2/20/98]

4.13.5.9.2 The MCO shall not take punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, consistent with the requirements in Section 4.5.5 (Expedited Appeal). [42 CFR 438.410(b)]

4.13.5.10 Anti-Discrimination

4.13.5.10.1 The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification or against any Provider that serves high-risk populations or specializes in conditions that require costly treatment.

4.13.5.10.2 This paragraph shall not be construed to prohibit an organization from:

4.13.5.10.2.1. Including Providers only to the extent necessary to meet the needs of the organization's Members,

4.13.5.10.2.2. Establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or

4.13.5.10.2.3. Using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

4.13.5.10.3 If the MCO declines to include individual or groups of Providers in its network, it shall give the affected Providers written notice of the reason for the decision.

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4.13.5.10.4 In all contracts with Participating Providers, the MCO's Provider selection policies and procedures shall not discriminate against particular Providers that service high-risk populations or specialize in conditions that require costly treatment. [42 CFR 438.12(a)(2); 42 CFR 438.214(c)]

4.13.5.11 Access and Availability

4.13.5.11.1 The MCO shall ensure that Providers comply with the time and distance and wait standards, including but not limited to those described in Section 4.7.3 (Time and Distance Standards) and Section 4.7.3.4 (Additional Provider Standards).

4.13.5.12 Payment Models

4.13.5.12.1 The MCO shall negotiate rates with Providers in accordance with Section 4.14 (Alternative Payment Models) and Section 4.15 (Provider Payments) of this Agreement, unless otherwise specified by DHHS (e.g., for Substance Use Disorder Provider rates).

4.13.5.12.2 The MCO Provider contract shall contain full and timely disclosure of the method and amount of compensation, payments, or other consideration, to be made to and received by the Provider from the MCO, including for Providers paid by an MCO Subcontractor, such as the PBM.

4.13.5.12.3 The MCO Provider contract shall detail how the MCO shall meet its reporting obligations to Providers as described within this Agreement.

4.13.5.13 Non-Exclusivity

4.13.5.13.1 The MCO shall not require a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

4.13.5.14 Proof of Membership

4.13.5.14.1 The MCO Provider contract shall require Providers in the MCO network to accept the Member's Medicaid identification card as proof of enrollment in the MCO until the Member receives his/her MCO identification card.

4.13.5.15 Other Provisions

4.13.5.15.1 The MCO's Provider contract shall also contain:

4.13.5.15.1.1. All required activities and obligations of the Provider and related reporting responsibilities.

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4.13.5.15.1.2. Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement.

4.13.5.15.1.3. A requirement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority.

4.13.6 Reporting

4.13.6.1 The MCO shall comply with and complete all reporting in accordance with Exhibit O, this Agreement, and as further specified by DHHS.

4.13.6.2 The MCO shall implement and maintain arrangements or procedures for notification to DHHS when it receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the managed care program, including the termination of the Provider agreement with the MCO. [42 CFR 438.608(a)(4)]

4.13.6.3 The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the Participating Provider network.

4.13.6.4 As part of the notice, the MCO shall submit a Transition Plan to DHHS to address continued Member access to needed service and how the MCO shall maintain compliance with its contractual obligations for Member access to needed services.

4.13.6.5 A significant change is defined as:

4.13.6.5.1 A decrease in the total number of PCPs by more than five percent (5%);

4.13.6.5.2 A loss of all Providers in a specific specialty where another Provider in that specialty is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement;

4.13.6.5.3 A loss of a hospital in an area where another contracted hospital of equal service ability is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement; and/or

4.13.6.5.4 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to Participating Providers.

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4.13.6.6 The MCO shall provide to DHHS and/or its DHHS Subcontractors (e.g., the EQRO) Provider participation reports on an annual basis or as otherwise determined by DHHS in accordance with Exhibit O; these may include but are not limited to Provider participation by geographic location, categories of service, Provider type categories, Providers with open panels, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze Provider service capacity in terms of Member access to health care.

4.14 Alternative Payment Models

4.14.1 As required by the special terms and conditions of The NH Building Capacity for Transformation waiver, NH is implementing a strategy to expand use of APMs that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to DHHS, Providers, and the stakeholder community.

4.14.2 In developing and refining its APM strategy, DHHS relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the "HCP-LAN APM framework") in order to:

4.14.2.1 Clearly and effectively communicate DHHS requirements through use of the defined categories established by HCP-LAN;

4.14.2.2 Encourage the MCO to align MCM APM offerings to other payers' APM initiatives to minimize Provider burden; and

4.14.2.3 Provide an established framework for monitoring MCO performance on APMs.

4.14.3 Prior to and/or over the course of the Term of this Agreement, DHHS shall develop the DHHS Medicaid APM Strategy, which may result in additional guidance, templates, worksheets and other materials that elucidate the requirements to which the MCO is subject under this Agreement.

4.14.4 Within the guidance parameters established and issued by DHHS and subject to DHHS approval, the MCO shall have flexibility to design Qualifying APMs (as defined in Section 4.14 of this Agreement) consistent with the DHHS Medicaid APM strategy and in conformance with CMS guidance.

4.14.5 The MCO shall support DHHS in developing the DHHS Medicaid APM Strategy through participation in stakeholder meetings and planning efforts, providing all required and otherwise requested information related to APMs; sharing data and analysis, and other activities as specified by DHHS.

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4.14.6 For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and DHHS shall ensure that it:

4.14.6.1 Makes participation in the APM available, using the same terms of performance, to a class of Providers providing services under the contract related to the reform or improvement initiative;

4.14.6.2 Uses a common set of performance measures across all the Providers;

4.14.6.3 Does not set the amount or frequency of the expenditures; and

4.14.6.4 Does not permit DHHS to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

4.14.7 Required Use of Alternative Payment Models Consistent with the New Hampshire Building Capacity for Transformation Waiver

4.14.7.1 Consistent with the requirements set forth in the special terms and conditions of NH's Building Capacity for Transformation waiver, the MCO shall ensure through its APM Implementation Plan (as described in Section 4.14) that fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs, as defined by DHHS, within the first twelve (12) months of this Agreement, subject to the following exceptions:

4.14.7.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have eighteen (18) months to meet this requirement; and

4.14.7.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS.

4.14.7.1.2.1. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6) months after the initial 18 month period.

4.14.7.1.2.2. For failure to meet this requirement, DHHS reserves to right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N, Section 3.2 (Liquidated Damages Matrix).

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4.14.7.2 MCO Incentives and Penalties for APM Implementation

4.14.7.2.1 Consistent with RSA 126-AA, the MCO shall include, through APMs and other means, Provider alignment incentives to leverage the combined DHHS, MCO, and providers to achieve the purpose of the incentives.

4.14.7.2.2 MCOs shall be subject to incentives, at DHHS' sole discretion, and/or penalties to achieve improved performance, including preferential auto-assignment of new members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

4.14.8 Qualifying Alternative Payment Models

4.14.8.1 A Qualifying APM is a payment approach approved by DHHS as consistent with the standards specified in this Section 4.14.8 (Qualifying Alternative Payment Models) and the DHHS Medicaid APM Strategy.

4.14.8.2 [Amendment #5:] At minimum, a Qualifying APM shall meet the requirements of the HCP-LAN APM framework Category 2B 2C, based on the refreshed 2017 framework released on July 11, 2017 and all subsequent revisions.

4.14.8.3 [Amendment #5:] As indicated in the HCP-LAN APM framework white paper, Category 2B 2C is met if the payment arrangement between the MCO and Participating Provider(s) rewards Participating Providers at a minimum for reporting quality metrics. ~~that perform well on quality metrics and/or penalizes Participating Providers that do not perform well on those metrics.~~

4.14.8.4 [Amendment #5:] HCP-LAN Categories 2B, 3A, 3B, 4A, 4B, and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy.

4.14.8.5 DHHS shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.14.10.2 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to DHHS, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.

4.14.8.6 Under no circumstances shall DHHS consider a payment methodology that takes cost of care into account without also considering quality a Qualifying APM.

4.14.8.7 Standards for Large Providers and Provider Systems

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4.14.8.7.1 The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the DHHS Medicaid APM Strategy.

4.14.8.8 Treatment of Payments to Community Mental Health Programs

4.14.8.8.1 The CMH Program payment model prescribed by DHHS in Section 4.11.5.1 (Contracting for Community Mental Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.8.2 At the sole discretion of DHHS, additional payment models specifically required by and defined as an APM by DHHS shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.9 [Amendment #5:] Accommodations for Other Providers Small Providers

4.14.8.9.1 [Amendment #5:] The MCO ~~may~~ shall develop Qualifying APM models appropriate for small Providers, and/or Federally Qualified Health Centers (FQHCs), as further defined by the DHHS Medicaid APM Strategy.

4.14.8.9.2 For example, the MCO may propose to DHHS models that incorporate pay-for-performance bonus incentives and/or 'per Member per month payments related to Providers' success in meeting actuarially-relevant cost and quality targets.

4.14.8.10 Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health

4.14.8.10.1 The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden and promote the integration of Behavioral Health.

4.14.8.10.2 [Amendment #5:] The MCO ~~shall~~ may incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Payer Advanced APM" (including but not limited to a Medicaid Medical Home Model) under the requirements of the Quality Payment Program as set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

4.14.9 MCO Alternative Payment Model Implementation Plan

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4.14.9.1 The MCO shall submit to DHHS for review and approval an APM Implementation Plan in accordance with Exhibit O.

4.14.9.2 The APM Implementation Plan shall meet the requirements of this section and of any subsequent guidance issued as part of the DHHS Medicaid APM Strategy.

4.14.9.3 Additional details on the timing, format, and required contents of the MCO APM Implementation Plan shall be specified by DHHS in Exhibit O and/or through additional guidance.

4.14.9.4 Alternative Payment Model Transparency

4.14.9.4.1 The MCO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the MCO's methodology, as well as the basis for developing and assessing Participating Provider performance in the APM, as described in Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how integration is promoted by the model among the MCO, Providers, and Members.

4.14.9.5 Provider Engagement and Support

4.14.9.5.1 The APM Implementation Plan shall describe a logical and reasonably achievable approach to implementing APMs, supported by an understanding of NH Medicaid Providers' readiness for participation in APMs, and the strategies the MCO shall use to assess and advance such readiness over time.

4.14.9.5.2 The APM Implementation Plan shall outline in detail what strategies the MCO plans to use, such as, meetings with Providers and IDNs, as appropriate, and the frequency of such meetings, the provision of technical support, and a data sharing strategy for Providers reflecting the transparency, reporting and data sharing obligations herein and in the DHHS Medicaid APM Strategy.

4.14.9.5.3 The MCO APM Implementation Plan shall ensure Providers and IDNs, as appropriate, are supported by data sharing and performance analytic feedback systems and tools that make actuarially sound and actionable provider level and system level clinical, cost, and performance data available to Providers in a timely manner for purposes of developing APMs and analyzing performance and payments pursuant to APMs.

4.14.9.5.4 MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

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4.14.9.6 Implementation Approach

4.14.9.6.1 The MCO shall include in the APM Implementation Plan a detailed description of the steps the MCO shall take to advance its APM Implementation Plan:

4.14.9.6.1.1. In advance of the Program Start Date;

4.14.9.6.1.2. During the first year of this Agreement;
and

4.14.9.6.1.3. Into the second year and beyond,
clearly articulating its long-term vision and goals for the
advancement of APMs over time.

4.14.9.6.2 The APM Implementation Plan shall include the MCO's plan for providing the necessary data and information to participating APM Providers to ensure Providers' ability to successfully implement and meet the performance expectations included in the APM, including how the MCO shall ensure that the information received by Participating Providers is meaningful and actionable.

4.14.9.6.3 The MCO shall provide data to Providers and IDNs, as appropriate, that describe the retrospective cost and utilization patterns for Members, which shall inform the strategy and design of APMs.

4.14.9.6.4 For each APM entered into, the MCO shall provide timely and actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM.

4.14.9.6.5 In addition, the MCO shall provide Member and Provider level data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions.

4.14.9.6.6 The APM Implementation Plan shall describe in example form to DHHS the level of information that shall be given to Providers that enter into APM Agreements with the MCO, including if the level of information shall vary based on the Category and/or type of APM the Provider enters.

4.14.9.6.7 The information provided shall be consistent with the requirements outlined under Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The MCOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

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4.14.10 Alternative Payment Model Transparency and Reporting Requirements

4.14.10.1 Transparency

4.14.10.1.1 In the MCO APM Implementation Plan, the MCO shall provide to DHHS for each APM, as applicable, the following information at a minimum:

4.14.10.1.1.1. The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.14.10.1.1.2. The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, the attachment points for cost targets, and risk adjustment methodology;

4.14.10.1.1.3. The approach to determining quality benchmarks and evaluating Provider performance, including advance communication of the specific measures that shall be used to determine quality performance, the methodology for calculating and assessing Provider performance, and any quality gating criteria that may be included in the APM design; and

4.14.10.1.1.4. The frequency at which the MCO shall regularly report cost and quality data related to APM performance to Providers, and the information that shall be included in each report.

4.14.10.1.2 Additional information may be required by DHHS in supplemental guidance. All information provided to DHHS shall be made available to Providers eligible to participate in or already participating in the APM unless the MCO requests and receives DHHS approval for specified information not to be made available.

4.14.10.2 Standardized Assessment of Alternative Payment Model Usage

4.14.10.2.1 The MCO shall complete, attest to the contents of, and submit to DHHS the HCP-LAN APM assessment²⁷ in accordance with Exhibit O.

²⁷ The MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).

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4.14.10.2.2 Thereafter, the MCO shall complete, attest to the contents of, and submit to DHHS the HCP-LAN APM assessment in accordance with Exhibit O and/or the DHHS Medicaid APM Strategy.

4.14.10.2.3 If the MCO reaches an agreement with DHHS that its implementation of the required APM model(s) may be delayed, the MCO shall comply with all terms set forth by DHHS for the additional and/or alternative timing of the MCO's submission of the HCP-LAN APM assessment.

4.14.10.3 Additional Reporting on Alternative Payment Model Outcomes

4.14.10.3.1 The MCO shall provide additional information required by DHHS in Exhibit O or other DHHS guidance on the type, usage, effectiveness and outcomes of its APMs.

4.14.11 Development Period for MCO Implementation

4.14.11.1 Consistent with the requirements for new MCOs, outlined in Section 4.14.8 (Qualifying Alternative Payment Models) above, DHHS acknowledges that MCOs may require time to advance their MCO Implementation Plan. DHHS shall provide additional detail, in its Medicaid APM Strategy, that describes how MCOs should expect to advance use of APMs over time.

4.14.12 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters

4.14.12.1 [Amendment #5:] The MCO's APM Implementation Plan shall indicate the quantitative, measurable clinical outcomes the MCO seeks to improve through its APM and QAPI initiative(s).

4.14.12.2 At a minimum, the MCO shall address the priorities identified in this Section 4.14.12 (Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters) and all additional priorities identified by DHHS in the DHHS Medicaid APM Strategy.

4.14.12.3 State Priorities in RSA 126-AA

4.14.12.3.1 [Amendment #5:] The MCO's APM Implementation Plan and/or QAPI Plan shall address the following priorities:

4.14.12.3.1.1. Opportunities to decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;

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4.14.12.3.1.2. Opportunities to reduce preventable admissions and thirty (30)-day hospital readmission for all causes;

4.14.12.3.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of NAS births;

4.14.12.3.1.4. Opportunities to better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with IDNs to advance the goals of the Building Capacity for Transformation waiver;

4.14.12.3.1.5. Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing generic prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing polypharmacy, as described in Section 4.2.5 (Medication Management);

4.14.12.3.1.6. Opportunities to enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.5 (Payment to Substance Use Disorder Providers) of this Agreement); and

4.14.12.3.1.7. Opportunities to address social determinants of health (further addressed in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address "ED boarding," in which Members that would be best treated in the community remain in the ED.

4.14.12.4 Alternative Payment Models for Substance Use Disorder Treatment

4.14.12.4.1 As is further described in Section 4.11.6.5 (Payment to Substance Use Disorder Providers), the MCO shall include in its APM Implementation Plan:

4.14.12.4.1.1. At least one (1) APM that promotes the coordinated and cost-effective delivery of high-quality care to infants born with NAS; and

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4.14.12.4.1.2. At least one (1) APM that promotes greater use of Medication-Assisted Treatment.

4.14.12.5 Emerging State Medicaid and Public Health Priorities

4.14.12.5.1 The MCO shall address any additional priorities identified by DHHS in the Medicaid APM Plan or related guidance.

4.14.12.5.2 If DHHS adds or modifies priorities after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of its APM Implementation Plan.

4.14.13 Physician Incentive Plans

4.14.13.1 The MCO shall submit all Physician Incentive Plans to DHHS for review as part of its APM Implementation Plan or upon development of Physician Incentive Plans that are separate from the MCO's APM Implementation Plan.

4.14.13.2 The MCO shall not implement Physician Incentive Plans until they have been reviewed and approved by DHHS.

4.14.13.3 Any Physician Incentive Plan, including those detailed within the MCO's APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to "MA organization," "CMS," and "Medicare beneficiaries" should be read as references to "MCO," "DHHS," and "Members," respectively. These include that:

4.14.13.3.1 The MCO may only operate a Physician Incentive Plan if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or Physician Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.14.13.3.2 If the MCO puts a physician or Physician Group at substantial financial risk for services not provided by the physician or Physician Group, the MCO shall ensure that the physician or Physician Group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(2); 42 CFR 438.3(i)]

4.14.13.4 The MCO shall submit to DHHS annually, at the time of its annual HCP-LAN assessment, a detailed written report of any implemented (and previously reviewed) Physician Incentive Plans, as described in Exhibit O.

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4.14.13.5 Annual Physician Incentive Plan reports shall provide assurance satisfactory to DHHS that the requirements of 42 CFR 438.208 are met. The MCO shall, upon request, provide additional detail in response to any DHHS request to understand the terms of Provider payment arrangements.

4.14.13.6 The MCO shall provide to Members upon request the following information:

4.14.13.6.1 Whether the MCO uses a Physician Incentive Plan that affects the use of referral services;

4.14.13.6.2 The type of incentive arrangement; and

4.14.13.6.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)].

4.15 Provider Payments

4.15.1 General Requirements

4.15.1.1 The MCO shall not, directly or indirectly, make payment to a physician or Physician Group or to any other Provider as an inducement to reduce or limit Medically Necessary Services furnished to a Member. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 438.3(i)]

4.15.1.2 The MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) [Section 1903 of the Social Security Act]:

4.15.1.2.1 Furnished under the MCO by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.

4.15.1.2.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act when the person knew or had any reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

4.15.1.2.3 Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the

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individual or entity, unless the State determines there is good cause not to suspend such payments.

4.15.1.2.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

4.15.1.2.5 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(2)(A) - (C) of the Social Security Act; section 1903(i)(16) - (17) of the Social Security Act]

4.15.1.3 No payment shall be made to a Participating Provider other than by the MCO for services covered under the Agreement between DHHS and the MCO, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR, or when DHHS makes direct payments to Participating Providers for graduate medical education costs approved under the Medicaid State Plan, or have been otherwise approved by CMS. [42 CFR 438.60]

4.15.1.4 The MCO shall reimburse Providers based on the Current Procedural Terminology (CPT) code's effective date. To the extent a procedure is required to be reimbursed under the Medicaid State Plan but no CPT code or other billing code has been provided by DHHS, the MCO shall contact DHHS and obtain a CPT code and shall retroactively reimburse claims based on the CPT effective date as a result of the CPT annual updates.

4.15.1.4.1 [Amendment #2:] For MCO provider contracts based on NH Medicaid fee schedules, the MCO shall reimburse providers for annual and periodic fee schedule adjustments in accordance with their effective dates.

4.15.1.5 The MCO shall permit Providers up to one hundred and twenty (120) calendar days to submit a timely claim. The MCO shall establish reasonable policies that allow for good cause exceptions to the one hundred and twenty (120) calendar day timeframe.

4.15.1.6 Good cause exceptions shall accommodate foreseeable and unforeseeable events such as:

4.15.1.6.1 A Member providing the wrong Medicaid identification number,

4.15.1.6.2 Natural disasters; or

4.15.1.6.3 Failed information technology systems.

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4.15.1.7 The Provider should be provided a reasonable opportunity to rectify the error, once identified, and to either file or re-file the claim.

4.15.1.8 Within the first one hundred and eighty (180) calendar days of the Program Start Date, DHHS has discretion to direct MCOs to extend the one hundred and twenty (120) calendar days on case by case basis.

4.15.1.9 The MCO shall pay interest on any Clean Claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

4.15.1.10 The MCO shall collect data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and Care Coordination efforts. [42 CFR 438.242(b)(3)(iii)]

4.15.1.11 The MCO shall implement and maintain arrangements or procedures for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud, to DHHS. [42 CFR 438.608(a)(2)]

4.15.2 Hospital-Acquired Conditions and Provider-Preventable Conditions

4.15.2.1 The MCO shall comply with State and federal laws requiring nonpayment to a Participating Provider for Hospital-Acquired Conditions and for Provider-Preventable Conditions.

4.15.2.2 The MCO shall not make payments to a Provider for a Provider-Preventable Condition that meets the following criteria:

4.15.2.2.1 Is identified in the Medicaid State Plan;

4.15.2.2.2 Has been found by NH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

4.15.2.2.3 Has a negative consequence for the Member;

4.15.2.2.4 Is auditable; and

4.15.2.2.5 Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.3(g); 42 CFR 438.6(a)(12)(i); 42 CFR 447.26(b)]

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4.15.2.3 The MCO shall require all Providers to report Provider-Preventable Conditions associated with claims for payment or Member treatments for which payment would otherwise be made, in accordance with Exhibit O. [42 CFR 438.3(g); 42 CFR 434.6(a)(12)(ii); 42 CFR 447.26(d)]

4.15.3 Federally Qualified Health Centers and Rural Health Clinics

4.15.3.1 FQHCs and RHCs shall be paid at minimum the encounter rate paid by DHHS at the time of service, and shall also be paid for DHHS-specified CPT codes outside of the encounter rates.

4.15.3.2 The MCO shall not provide payment to an FQHC or RHC that is less than the level and amount of payment which the MCO would make for the services if the services were furnished by a Provider which is not an FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Social Security Act]

4.15.3.3 [Amendment #5:] The MCO may shall enter into Alternative Payment Models with FQHCs, RHCs, and/or other health or family planning clinics or their designated contracting organizations as negotiated and agreed upon with DHHS in the MCO's APM Implementation Plan and as described by DHHS in the Medicaid APM Strategy.

4.15.4 Hospice Payment Rates

4.15.4.1 The Medicaid hospice payment rates shall be calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services.

4.15.5 Community Mental Health Programs

4.15.5.1 The MCO shall, as described in Section 4.11.5.2 (Payment to Community Mental Health Programs and Community Mental Health Providers), meet the specific payment arrangement criteria in contracts with CMH Programs and CMH Providers for services provided to Members.

4.15.5.2 [Amendment #3:] Subject to CMH Provider Agreement modification, the MCO shall waive its CMH Program contracted minimum Maintenance of Effort (MOE) requirements for the purpose of providing COVID-19 Public Health Emergency fiscal relief during the SFY 2020 period.

4.15.5.2.1 [Amendment #9:] "Maintenance of effort" (MOE), defined in the payer/provider contract for a specified period of time,

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commonly refers to minimum performance requirements which the provider must achieve to earn or retain all or a portion of the provider's capitated payments either through reimbursement withheld by the payer or adjusted after reconciliation and settlement of the provider's payment(s) for the period.

4.15.5.3 [Amendment #3:] Such MOE waiver described in Section 4.15.5.2 shall not inadvertently cause reductions in the MCO's CMH Program contracted capitation rates in future rating periods.

4.15.5.4 [Amendment #5]: The MCO shall not extend the MOE relief waiver described in Sections 4.15.5.2 and 4.15.5.3 beyond March 31, 2021, unless a Public Health Emergency is extended beyond the 31st in which case the MOE relief shall nonetheless end on June 30, 2021.

4.15.5.4.1 [Amendment #10:] [Amendment #8:] The MCO shall limit any MOE clawback that is determined to fifty percent (50%) for the period July 1, 2023 ~~2022~~ through August 31, 2024 ~~December 31, 2022~~; and limit MOE clawback to seventy percent (70%) for the period January 1, 2023 through June 30, 2023.

4.15.5.4.1.1. [Amendment #8:] The MCO shall include in their contracts with CMHCs, the following:

4.15.5.4.1.1.1 [Amendment #8:] Utilization of MOE thresholds in place for the SFY, 2021 fiscal period.

4.15.5.4.1.1.2 [Amendment #8:] CMHC requirements to explicitly reserve for MOE liability for failure to meet the threshold.

4.15.5.4.1.1.3 [Amendment #8:] Agreement the MCO shall clawback no more than fifty percent (50%) of any individual CMHC's MOE liability/reserve after the year end reconciliation is complete following two months of runout for SFY 2022.

4.15.5.4.1.1.4 [Amendment #8:] Requirements the CMHCs shall contractually commit to applying its portion of any "retained reserve account" to workforce and provide a detailed accounting to the Department.

4.15.5.4.1.1.5 [Amendment #8:] The MCO's clawback shall be calculated as a part of the Medical

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Loss Ratio provisions in the MCO's Agreement with DHHS.

4.15.5.4.1.1.6 [Amendment #8:] Should there be materiality of substituted services by non-CMHC Providers determined by the Department's actuary due to MOE adherence, the actuarial value and materiality of partial hospitalization services shall be acknowledged as such with a contractual adjustment.

4.15.5.5 [Amendment #6:] The MCO shall remit directed payment(s) to eligible Community Mental Health Programs (CMHPs) in accordance with separate guidance, as follows:

4.15.5.5.1 [Amendment #6:] For the rating period September 1, 2019 through June 30, 2020 directed payment amounts determined by DHHS shall comprise uniform dollar or percentage increases for Community Mental Health Programs for Assertive Community Treatment, Mobile Crisis Services, Same Day Access upon New Hampshire Hospital Discharge, and Step Down Community Residence Beds, as approved by CMS.

4.15.5.5.2 [Amendment #6:] For the rating period July 1, 2020 through June 30, 2021, directed payment amounts determined by DHHS shall comprise a uniform dollar increase for assertive community treatment services, mobile crisis response services, specialty residential services, same day/next day access upon hospital/designated receiving facility discharges, and step down community residence beds for individuals dually diagnosed with serious mental illness and development disabilities, as approved by CMS.

4.15.5.5.3 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment amounts determined by DHHS shall comprise a fee schedule adjustment or uniform dollar increase for assertive community treatment, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, consistent illness management and recovery services, and step down community residence beds for individuals dually diagnosed with serious mental illness and developmental disabilities, within the Community Mental Health Programs class of network providers as approved by CMS, including any alternate CMS-approved directed payment methodology.

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4.15.5.5.4 [Amendment #10:] [Amendment #8:] For the rating period July 1, 2023 2022 through August 31, 2024 June 30, 2023, directed payment amounts determined by DHHS shall comprise a fee schedule adjustment or uniform dollar increase for assertive community treatment, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, consistent illness management and recovery services, and step down community residence beds for individuals dually diagnosed with serious mental illness and developmental disabilities, within the Community Mental Health Programs class of network providers as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.5.6 [Amendment #7:] [Amendment #6:] The MCO shall reimburse remit directed payment(s) to eligible Community Mental Health Programs (CMHPs) for Community Residential Services, as follows:

4.15.5.6.1 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise a minimum fee schedule at least at the FFS rates established by DHHS for Community Residential Services.

4.15.5.6.2 [Amendment #10:] [Amendment #8:] For the rating period July 1, 2023 2022 through August 31, 2024 June 30, 2023, directed payment remittance shall comprise a minimum fee schedule at least at the FFS rates established by DHHS for Community Residential Services.

4.15.6 Payment Standards for Substance Use Disorder Providers

4.15.6.1 The MCO shall, as described in Section 4.11.6 (Substance Use Disorder), reimburse Substance Use Providers as directed by DHHS.

4.15.7 Payment Standards for Private Duty Nursing Services

4.15.7.1 The MCO shall reimburse private duty nursing agencies for private duty nursing services at least at the FFS rates established by DHHS.

4.15.8 Payment Standards for Indian Health Care Providers

4.15.8.1 The MCO shall pay IHCPs, whether Participating Providers or not, for Covered Services provided to American Indian Members who are eligible to receive services at a negotiated rate between the MCO and the IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the MCO

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would make for the services to a Participating Provider that is not an IHCP. [42 CFR 438.14(b)(2)(i) -(ii)]

4.15.8.2 For contracts involving IHCPs, the MCO shall meet the requirements of FFS timely payment for all I/T/U Providers in its network, including the paying of ninety-five percent (95%) of all Clean Claims within thirty (30) calendar days of the date of receipt; and paying ninety-nine percent (99%) of all Clean Claims within ninety (90) calendar days of the date of receipt. [42 CFR 438.14(b)(2)(iii); ARRA 5006(d); 42 CFR 447.45; 42 CFR 447.46; SMDL 10-001]

4.15.8.3 IHCPs enrolled in Medicaid as FQHCs but not Participating Providers of the MCO shall be paid an amount equal to the amount the MCO would pay an FQHC that is a Participating Provider but is not an IHCP, including any supplemental payment from DHHS to make up the difference between the amount the MCO pays and what the IHCPs FQHC would have received under FFS. [42 CFR 438.14(c)(1)]

4.15.8.4 When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medicaid State Plan's FFS payment methodology. [42 CFR 438.14(c)(2)]

4.15.8.5 When the amount the IHCP receives from the MCO is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, DHHS shall make a supplemental payment to the IHCP to make up the difference between the amount the MCO pays and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 CFR 438.14(c)(3)]

4.15.9 Transition Housing Program

The MCO shall reimburse Transition Housing Program services at least at the FFS rates established by DHHS.

4.15.10 Payment Standards for DME Providers

4.15.10.1 [Amendment #6:] Beginning January 1, 2020, the MCO shall reimburse DME Providers for DME and DME related services, as follows:
~~[Base Contract:] No earlier than January 1, 2020, the MCO shall reimburse DME Providers for DME and DME related services at 80% of the FFS rates established by DHHS.~~

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4.15.10.1.1 [Amendment #6:] For the rating period September 1, 2019 through June 30, 2020, directed payment remittance shall comprise a minimum fee schedule at 80% of the DHHS FFS fee schedule, as approved by CMS.

4.15.10.1.2 [Amendment #6:] For the rating period July 1, 2020 through June 30, 2021, directed payment remittance shall comprise a minimum fee schedule at 80% of the DHHS FFS fee schedule, as approved by CMS.

4.15.10.1.3 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise a minimum fee schedule at 80% of the DHHS FFS fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.10.1.4 [Amendment #8:] For the rating period July 1, 2022 through June 30, 2023, MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.10.1.5 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.11 [Amendment #3:] Payment Standards for Certain Providers Affected by the COVID-19 Public Health Emergency

4.15.11.1 [Amendment #6:] The MCO shall remit directed payments related to the COVID 19 Public Health Emergency in accordance with separate guidance, as follows: [Amendment #3:] The MCO shall cooperate in implementing CMS-approved COVID-19 Public Health Emergency related directed payments in accordance with prescribed DHHS guidance.

4.15.11.1.1 [Amendment #6:] For the rating period September 1, 2019 through June 30, 2020, directed payment amounts determined by DHHS shall comprise a uniform percent increase to defined safety net provider classes as approved by CMS.

4.15.11.2 [Amendment #7:] The MCO shall remit directed payments related to funding available through the American Rescue Plan Act of 2021 (ARPA) Section 9817, as follows:

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4.15.11.2.1 [Amendment #7:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise an additional payment calculated by DHHS at a percentage payment increase to defined Home and Community Based Service (HCBS) provider classes (e.g., private duty nursing, home care, personal care, durable medical equipment, substance use disorder residential providers, Community Mental Health Centers) for specified codes in accordance with separate guidance and as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.12 [Amendment #4:] Payment Standards for Directed Payments

4.15.12.1 [Amendment #4:] Any directed payments proposed to CMS shall be described in the program's actuarial certification for the rating period.

4.15.12.2 [Amendment #7:] The term "minimum fee schedule" in this Section 4.15, shall infer the minimum provider reimbursement amount(s) permissible under the terms of this Agreement.

4.15.13 [Amendment #6:] Critical Access Hospitals (CAHs)

4.15.13.1 [Amendment #6:] The MCO shall remit directed payment(s) to CAHs in accordance with separate guidance, as follows:

4.15.13.1.1 [Amendment #6:] For the rating period July 1, 2020 through June 30, 2021, directed payment amounts determined by DHHS shall comprise a uniform rate increase for inpatient discharges and outpatient visits to qualifying CAHs as approved by CMS.

4.15.13.1.2 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.13.1.3 [Amendment #8:] For the rating period July 1, 2022 through June 30, 2023, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology.

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4.15.13.1.4 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology. Qualified directed payments are tied to actual hospital services, including the number of inpatient discharges and outpatient visits reported by qualifying Providers.

4.15.14 [Amendment #6:] Designated Receiving Facilities (DRFs)

4.15.14.1 [Amendment #7] [Amendment #6:] The MCO shall remit minimum directed payments to ~~DHHS approved NH~~ Medicaid enrolled DRFs as designated by the Commissioner, ~~in accordance with separate guidance~~, as follows:

4.15.14.1.1 [Amendment #7] [Amendment #6:] For the July 1, 2021 through June 30, 2022 rating period, the MCO directed payment remittance to the Peer Group 06 provider shall comprise the minimum ~~Peer Group 01 and 07, Peer Group 02, Peer Group 06, and Peer Group 09~~ State Plan DRG fee schedule payment amounts described in Section 6.2.41.1, and the State Plan rate for Hampstead Hospital.

4.15.14.1.2 [Amendment #8:] For the July 1, 2022 through June 30, 2023 rating period, the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 State Plan DRG fee schedule payment amounts described in Section 6.2.41.1.

4.15.14.1.3 [Amendment #10:] For the July 1, 2023 through August 31, 2024 rating period, the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 State Plan DRG fee schedule payment amounts described in Section 6.2.41.1.

4.15.15 [Amendment #7:] Neuropsychological Testing Services

4.15.15.1 [Amendment #7:] Beginning July 1, 2021, the MCO shall reimburse eligible providers for covered neuropsychological testing services, as follows:

4.15.15.1.1 [Amendment #7:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

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4.15.15.1.2 [Amendment #8] For the rating period July 1, 2022 through June 30, 2023, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.15.1.3 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.16 [Amendment #8:] New Hampshire Hospital and Hampstead Hospital

4.15.16.1 [Amendment #10] [Amendment #8:] ~~Beginning July 1, 2022, the~~The MCO shall reimburse inpatient psychiatric services delivered in state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

4.15.16.1.1 [Amendment #8:] For the rating period July 1, 2022 through June 30, 2023, the facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

4.15.16.1.2 [Amendment #10:] [Amendment #8:] For the rating period July 1, 2023 through August 31, 2024~~June 30, 2023~~, the facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

4.15.16.2 [Amendment #10:] The MCO shall reimburse inpatient psychiatric professional services delivered in the state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

4.15.16.2.1 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, directed payment amounts shall comprise minimum fee schedule payments at no less than the Medicare rates for inpatient psychiatric professional services delivered in the state-owned facilities.

4.15.17 [Amendment #10:] Payment Standard for Birthing Centers

4.15.17.1 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services at no less than NH Medicaid fee schedule rates.

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4.15.18 [Amendment #10:] Qualifying Children's Hospitals

4.15.18.1 [Amendment #10:] The MCO shall remit directed payments to qualifying Children's Hospitals substantively serving NH Medicaid Members, in accordance with separate guidance, as follows:

4.15.18.2 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, a directed payment add-on amount in addition to the MCO's negotiated rate shall be awarded to qualifying Children's Hospitals for each eligible inpatient and outpatient hospital service encounter as approved by CMS.

4.15.19 [Amendment #10:] Payment Standard for Ambulance Services

4.15.19.1 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Providers for all ambulance and chair car Covered Services at no less than NH Medicaid fee schedule rates.

4.16 Readiness Requirements Prior to Operations

4.16.1 General Requirements

4.16.1.1 Prior to the Program Start Date, the MCO shall demonstrate to DHHS's satisfaction its operational readiness and its ability to provide Covered Services to Members at the start of this Agreement in accordance with 42 CFR 438.66(d)(2), (d)(3), and (d)(4). [42 CFR 437.66(d)(1)(i).

4.16.1.2 The readiness review requirements shall apply to all MCOs regardless of whether they have previously contracted with DHHS. [42 CFR 438.66((D(1)(II))]

4.16.1.3 The MCO shall accommodate Readiness desk and site Reviews, including documentation review and system demonstrations as defined by DHHS.

4.16.1.4 The readiness review requirements shall apply to all MCOs, including those who have previously covered benefits to all eligibility groups covered under this Agreement. [42 CFR 438.66(d)(2), (d)(3) and (d)(4)]

4.16.1.5 In order to demonstrate its readiness, the MCO shall cooperate in the Readiness Review conducted by DHHS.

4.16.1.6 If the MCO is unable to demonstrate its ability to meet the requirements of this Agreement, as determined solely by DHHS, within the timeframes determined solely by DHHS, then DHHS shall

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have the right to terminate this Agreement in accordance with Section 7.1 (Termination for Cause).

4.16.1.7 The MCO shall participate in all DHHS trainings in preparation for implementation of the Agreement.

4.16.2 Emergency Response Plan

4.16.2.1 The MCO shall submit an Emergency Response Plan to DHHS for review prior to the Program Start Date.

4.16.2.2 The Emergency Response Plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

4.16.2.2.1 Staff and Provider training;

4.16.2.2.2 Essential business functions and key employees within the organization necessary to carry them out;

4.16.2.2.3 Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

4.16.2.2.4 Communication with staff, Members, Providers, Subcontractors and suppliers when normal systems are unavailable;

4.16.2.2.5 Plans to ensure continuity of services to Providers and Members;

4.16.2.2.6 How the MCO shall coordinate with and support DHHS and the other MCOs; and

4.16.2.2.7 How the plan shall be tested, updated and maintained.

4.16.2.3 On an annual basis, or as otherwise specified in Exhibit O, the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.

4.17 Managed Care Information System

4.17.1 System Functionality

4.17.1.1 The MCO shall have a comprehensive, automated, and integrated MCIS that:

4.17.1.1.1 Collects, analyzes, integrates, and reports data [42 CFR 438.242(a)];

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4.17.1.1.2 Provides information on areas, including but not limited to utilization, claims, grievances and appeals [42 CFR 438.242(a)];

4.17.1.1.3 Collects and maintains data on Members and Providers, as specified in this Agreement and on all services furnished to Members, through an Encounter Data system [42 CFR 438.242(b)(2)];

4.17.1.1.4 Is capable of meeting the requirements listed throughout this Agreement; and

4.17.1.1.5 Is capable of providing all of the data and information necessary for DHHS to meet State and federal Medicaid reporting and information regulations.

4.17.1.2 The MCO's MCIS shall be capable of submitting Encounter Data, as detailed in Section 5.1.3 (Encounter Data) of this Agreement. The MCO shall provide for:

4.17.1.2.1 Collection and maintenance of sufficient Member Encounter Data to identify the Provider who delivers any item(s) or service(s) to Members;

4.17.1.2.2 Submission of Member Encounter Data to DHHS at the frequency and level of detail specified by CMS and by DHHS;

4.17.1.2.3 Submission of all Member Encounter Data that NH is required to report to CMS; and

4.17.1.2.4 Submission of Member Encounter Data to DHHS in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as specified in this Agreement. [42 CFR 438.242(c)(1) - (4); 42 CFR 438.818]

4.17.1.3 All Subcontractors shall meet the same standards, as described in this Section 4.17 (Managed Care Information System) of the Agreement, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a Subcontractor with respect to its provided functions.

4.17.1.4 The MCO MCIS shall include, but not be limited to:

4.17.1.4.1 Management of Recipient Demographic Eligibility and Enrollment and History;

4.17.1.4.2 Management of Provider Enrollment and Credentialing;

4.17.1.4.3 Benefit Plan Coverage Management, History, and Reporting;

4.17.1.4.4 Eligibility Verification;

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- 4.17.1.4.5 Encounter Data;
 - 4.17.1.4.6 Reference File Updates;
 - 4.17.1.4.7 Service Authorization Tracking, Support and Management;
 - 4.17.1.4.8 Third Party Coverage and Cost Avoidance Management;
 - 4.17.1.4.9 Financial Transactions Management and Reporting;
 - 4.17.1.4.10 Payment Management (Checks, electronic funds transfer (EFT), Remittance Advices, Banking);
 - 4.17.1.4.11 Reporting (Ah hoc and Pre-Defined/Scheduled and On-Demand);
 - 4.17.1.4.12 Call Center Management;
 - 4.17.1.4.13 Claims Adjudication;
 - 4.17.1.4.14 Claims Payments; and
 - 4.17.1.4.15 QOS metrics.
- 4.17.1.5 Specific functionality related to the above shall include, but is not limited to, the following:
- 4.17.1.5.1 The MCIS Membership management system shall have the capability to receive, update, and maintain NH's Membership files consistent with information provided by DHHS;
 - 4.17.1.5.2 The MCIS shall have the capability to provide daily updates of Membership information to subcontractors or Providers with responsibility for processing claims or authorizing services based on Membership information;
 - 4.17.1.5.3 The MCIS's Provider file shall be maintained with detailed information on each Provider sufficient to support Provider enrollment and payment and also meet DHHS's reporting and Encounter Data requirements;
 - 4.17.1.5.4 The MCIS's claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system;
 - 4.17.1.5.5 The MCIS's Services Authorization system shall be integrated with the claims processing system;

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4.17.1.5.6 The MCIS shall be able to maintain its claims history with sufficient detail to meet all DHHS reporting and encounter requirements;

4.17.1.5.7 The MCIS's credentialing system shall have the capability to store and report on Provider specific data sufficient to meet the Provider credentialing requirements, Quality Management, and Utilization Management Program Requirements;

4.17.1.5.8 [Amendment #5:] The MCIS shall be bi-directionally linked to the other operational systems maintained by DHHS, in order to ensure that data captured in encounter records accurately matches data in Member, Provider, claims and authorization files, and in order to enable Encounter Data to be utilized for Member profiling, Provider profiling, claims validation, fraud, waste and abuse monitoring activities, quality improvement, and any other research and reporting purposes defined by DHHS; and

4.17.1.5.9 The Encounter Data system shall have a mechanism in place to receive, process, and store the required data.

4.17.1.6 The MCO system shall be compliant with the requirements of HIPAA and 42 CFR Part 2, including privacy, security, NPI, and transaction processing, including being able to process electronic data interchange (EDI) transactions in the ASC 5010 format. This also includes IRS Pub 1075 where applicable.

4.17.1.7 The MCO system shall be compliant with Section 6504(a) of the Affordable Care Act, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act. [42 CFR 438.242(b)(1)]

4.17.1.8 MCIS capability shall include, but not be limited to the following:

4.17.1.8.1 Provider network connectivity to EDI and Provider portal systems;

4.17.1.8.2 Documented scheduled down time and maintenance windows, as agreed upon by DHHS, for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

4.17.1.8.3 DHHS on-line web access to applications and data required by the State to utilize agreed upon workflows, processes,

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and procedures (reviewed by DHHS) to access, analyze, or utilize data captured in the MCO system(s) and to perform appropriate reporting and operational activities;

4.17.1.8.4 DHHS access to user acceptance testing (UAT) environment for externally accessible systems including websites and secure portals;

4.17.1.8.5 Documented instructions and user manuals for each component; and

4.17.1.8.6 Secure access.

4.17.1.9 Managed Care Information System Up-Time

4.17.1.9.1 Externally accessible systems, including telephone, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year, except for scheduled maintenance upon notification of and pre-approval by DHHS. The maintenance period shall not exceed four (4) consecutive hours without prior DHHS approval.

4.17.1.9.2 MCO shall provide redundant telecommunication backups and ensure that interrupted transmissions shall result in immediate failover to redundant communications path as well as guarantee data transmission is complete, accurate and fully synchronized with operational systems.

4.17.2 Information System Data Transfer

4.17.2.1 Effective communication between the MCO and DHHS requires secure, accurate, complete, and auditable transfer of data to/from the MCO and DHHS data management information systems. Elements of data transfer requirements between the MCO and DHHS management information systems shall include, but not be limited to:

4.17.2.1.1 DHHS read access to all MCM data in reporting databases where data is stored, which includes all tools required to access the data at no additional cost to DHHS;

4.17.2.1.2 Exchanges of data between the MCO and DHHS in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target;

4.17.2.1.3 Secure (encrypted) communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to



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identify and resolve issues according to the timelines set forth by the State;

4.17.2.1.4 Collaborative relationships with DHHS, its MMIS fiscal agent, and other interfacing entities to effectively implement the requisite exchanges of data necessary to support the requirements of this Agreement;

4.17.2.1.5 MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

4.17.2.1.6 Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling that, to the maximum extent possible, automate the ETL processes, and provide for source to target or source to specification mappings;

4.17.2.1.7 Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts; and

4.17.2.1.8 A given day's data transmissions, as specified in this Section 4.17.2 (Information System Data Transfer) of the Agreement, are to be downloaded to DHHS according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions shall be included in the next batch transmission.

4.17.2.2 The MCO shall designate a single point of contact to coordinate data transfer issues with DHHS.

4.17.2.3 DHHS shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and DHHS staff for project plans documentation, issues tracking, deliverables, and other project-related artifacts.

4.17.2.4 Data transmissions from DHHS to the MCO shall include, but not be limited to the following:

4.17.2.4.1 Provider Extract (Daily);

4.17.2.4.2 Recipient Eligibility Extract (Daily);

4.17.2.4.3 Recipient Eligibility Audit/Roster (Monthly);

4.17.2.4.4 Medical and Pharmacy Service Authorizations (Daily);

4.17.2.4.5 Medicare and Commercial Third Party Coverage (Daily);

4.17.2.4.6 Claims History (Bi-Weekly); and

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4.17.2.4.7 Capitation Payment data (Monthly).

4.17.2.5 Data transmissions from the MCO to DHHS shall include, but not be limited to the following:

4.17.2.5.1 Member Demographic changes (Daily);

4.17.2.5.2 Member Primary Care Physician Selection (Daily);

4.17.2.5.3 MCO Provider Network Data (Daily);

4.17.2.5.4 Medical and Pharmacy Service Authorizations (Daily);

4.17.2.5.5 Member Encounter Data including paid, denied, adjustment transactions by pay period (Weekly);

4.17.2.5.6 Financial Transaction Data (Weekly);

4.17.2.5.7 Updates to Third Party Coverage Data (Weekly); and

4.17.2.5.8 Behavioral Health Certification Data (Monthly).

4.17.2.6 The MCO shall provide DHHS staff with access to timely and complete data and shall meet the following requirements:

4.17.2.6.1 All exchanges of data between the MCO and DHHS shall be in a format, file record layout, and scheduled as prescribed by DHHS;

4.17.2.6.2 The MCO shall work collaboratively with DHHS, DHHS's MMIS fiscal agent, the NH Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

4.17.2.6.3 The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide DHHS with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between DHHS and the MCO, including any MCO/Subcontractor locations supporting the NH program;

4.17.2.6.4 The MCO shall provide support to DHHS and its fiscal agent to prove the validity, integrity and reconciliation of its data, including Encounter Data;

4.17.2.6.5 The MCO shall be responsible for correcting data extract errors in a timeline set forth by DHHS as outlined within this Agreement;

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4.17.2.6.6 Access shall be secure and data shall be encrypted in accordance with HIPAA regulations and any other applicable State and federal law; and

4.17.2.6.7 Secure access shall be managed via passwords/pins/and any operational methods used to gain access as well as maintain audit logs of all users.access to the system.

4.17.3 Systems Operation and Support

4.17.3.1 Systems operations and support shall include, but not be limited to:

4.17.3.1.1 On-call procedures and contacts;

4.17.3.1.2 Job scheduling and failure notification documentation;

4.17.3.1.3 Secure (encrypted) data transmission and storage methodology;

4.17.3.1.4 Interface acknowledgements and error reporting;

4.17.3.1.5 Technical issue escalation procedures;

4.17.3.1.6 Business and Member notification;

4.17.3.1.7 Change control management;

4.17.3.1.8 Assistance with UAT and implementation coordination;

4.17.3.1.9 Documented data interface specifications – data imported and extracts exported including database mapping specifications;

4.17.3.1.10 Disaster Recovery and Business Continuity Plan;

4.17.3.1.11 Journaling and internal backup procedures, for which facility for storage shall be class 3 compliant; and

4.17.3.1.12 Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

4.17.3.2 The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and shall provide:

4.17.3.2.1 Network diagram that fully defines the topology of the MCO's network;

4.17.3.2.2 DHHS/MCO connectivity;

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4.17.3.2.3 Any MCO/Subcontractor locations requiring MCIS access/support; and

4.17.3.2.4 Web access for DHHS staff, Providers and recipients.

4.17.3.3 [Amendment #9:] The MCO shall utilize either its own or the State's open model Electronic Visit Verification (EVV) system as prescribed by the Department in separate guidance for all Medicaid personal care services and home health Covered Services that require an in-home visit by a Provider in accordance with Section 12006(a) of the 21st Century Cures Act. This applies to personal care services provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver, as applicable.

4.17.4 Ownership and Access to Systems and Data

4.17.4.1 The MCO shall make available to DHHS and, upon request, to CMS all collected data. [42 CFR 438.242(b)(4)]

4.17.4.2 All data accumulated as part of the MCM program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in the media format and schedule prescribed by DHHS, and affirmatively and securely destroyed if required by DHHS.

4.17.4.3 Systems enhancements developed specifically, and data accumulated, as part of the MCM program shall remain the property of the State. Source code developed for the MCM program shall remain the property of the MCO but shall be held in escrow.

4.17.4.4 The MCO shall not destroy or purge DHHS's data unless directed to or agreed to in writing by DHHS. The MCO shall archive data only on a schedule agreed upon by DHHS and the data archive process shall not modify the data composition of the source records. All DHHS archived data shall be retrievable for DHHS in the timeframe set forth by DHHS.

4.17.4.5 The MCO shall provide DHHS with system reporting capabilities that shall include access to pre-designed and agreed-upon scheduled reports, as well as the ability to respond promptly to ad-hoc requests to support DHHS data and information needs.

4.17.4.6 DHHS acknowledges the MCO's obligations to appropriately protect data and system performance, and the parties agree to work together to ensure DHHS information needs can be met while minimizing risk and impact to the MCO's systems.

4.17.4.7 Records Retention

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4.17.4.7.1 The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than ten (10) years from the date of termination of this Agreement.

4.17.4.7.2 Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation.

4.17.4.7.3 Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHHS, if DHHS approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

4.17.4.7.4 Upon expiration of the ten (10) year retention period and upon request, the subject records shall be transferred to DHHS's possession.

4.17.4.7.5 No records shall be destroyed or otherwise disposed of without the prior written consent of DHHS.

4.17.5 Web Access and Use by Providers and Members

4.17.5.1 The MCIS shall include web access for use by and support to Participating Providers and Members.

4.17.5.2 The services shall be provided at no cost to the Participating Provider or Members.

4.17.5.3 All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

4.17.5.4 The MCO shall create secure web access for Medicaid Providers and Members and authorized DHHS-staff to access case-specific information; this web access shall fulfill the following requirements, and shall be available no later than the Program Start Date:

4.17.5.4.1 Providers shall have the ability to electronically submit service authorization requests and access and utilize other Utilization Management tools;

4.17.5.4.2 Providers and Members shall have the ability to download and print any needed Medicaid MCO program forms and other information;

4.17.5.4.3 Providers shall have an option to e-prescribe without electronic medical records or hand held devices;

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4.17.5.4.4 The MCO shall support Provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es);

4.17.5.4.5 Providers shall have access to drug information;

4.17.5.4.6 The website shall provide an e-mail link to the MCO to permit Providers and Members or other interested parties to e-mail inquiries or comments.

4.17.5.4.7 The website shall provide a link to the State's Medicaid website;

4.17.5.4.8 The website shall be secure and HIPAA compliant in order to ensure the protection of PHI and Medicaid recipient confidentiality.

4.17.5.4.9 Access shall be limited to verified users via passwords and any other available industry standards.

4.17.5.4.10 Audit logs shall be maintained reflecting access to the system and random audits shall be conducted; and

4.17.5.4.11 The MCO shall ensure that any PHI, PI or other Confidential Information solicited on the website, shall not be stored or captured on the website and shall not be further disclosed except as provided by this Agreement.

4.17.5.5 The MCO shall manage Provider and Member access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist Providers and Members with gaining access and utilizing the web portal.

4.17.5.6 System Support Performance Standards shall include:

4.17.5.6.1 Email inquiries – one (1) business day response;

4.17.5.6.2 New information posted within one (1) business day of receipt, and up to two (2) business days of receipt for materials that shall be made ADA compliant with Section 508 of the Rehabilitation Act;

4.17.5.6.3 Routine maintenance;

4.17.5.6.4 Standard reports regarding portal usage such as hits per month by Providers/Members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports; and

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4.17.5.6.5 Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, Internet Explorer, Firefox, Safari, etc.). If user does not have compliant browser, MCO shall redirect user to site to install appropriate browser.

4.17.6 Contingency Plans and Quality Assurance

4.17.6.1 Critical systems within the MCIS support the delivery of critical medical services to Members and reimbursement to Providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

4.17.6.2 The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to NH within twenty-four (24) hours of incident onset.

4.17.6.3 The MCO shall ensure that the NH PHI data, data processing, and data repositories are securely segregated from any other account or project, and that MCIS is under appropriate configuration management and change management processes and subject to DHHS notification requirements.

4.17.6.4 The MCO shall manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files that reflect the source, type and user associated with a transaction.

4.17.6.5 Archiving processes shall not modify the data composition of DHHS's records, and archived data shall be retrievable at the request of DHHS. Archiving shall be conducted at intervals agreed upon between the MCO and DHHS.

4.17.6.6 The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between Providers, Provider billing agents/clearing houses, or DHHS and the MCO.

4.17.6.7 Audit logs of activities shall be maintained and periodically reviewed to ensure compliance with security and access rights granted to users.

4.17.6.8 In accordance with Exhibit O, the MCO shall submit the following documents and corresponding checklists for DHHSs review:

4.17.6.8.1 Disaster Recovery Plan;

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4.17.6.8.2 Business Continuity Plan;

4.17.6.8.3 Security Plan;

4.17.6.8.4 The following documents which, if after the original documents are submitted the MCO makes modifications to them, the revised redlined documents and any corresponding checklists shall be submitted for DHHS review:

4.17.6.8.4.1. Risk Management Plan,

4.17.6.8.4.2. Systems Quality Assurance Plan,

4.17.6.8.4.3. Confirmation of 5010 compliance and Companion Guides, and

4.17.6.8.4.4. Confirmation of compliance with IRS Publication 1075.

4.17.6.9 Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements, at a minimum, shall be part of the MCO's change management process:

4.17.6.9.1 The complete system shall have proper configuration management/change management in place (to be reviewed by DHHS).

4.17.6.9.2 The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

4.17.6.9.3 The MCO shall provide DHHS with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to Subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and DHHS and/or the fiscal agent.

4.17.6.9.4 DHHS retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

4.17.6.9.5 The MCO shall provide DHHS with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day.

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4.17.6.9.6 The MCO shall provide DHHS with official points of contact for MCIS issues on an ongoing basis.

4.17.6.9.7 A NH program centralized electronic repository shall be provided that shall permit full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and any project artifacts. All items shall be turned over to DHHS upon request.

4.17.6.9.8 The MCO shall ensure appropriate testing is done for all system changes. MCO shall also provide a test system for DHHS to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI data of any Member.

4.17.6.9.9 The MCO shall make timely changes or defect fixes to data interfaces and execute testing with DHHS and other applicable entities to validate the integrity of the interface changes.

4.17.6.10 DHHS, or its agent, may conduct a Systems readiness review to validate the MCO's ability to meet the MCIS requirements.

4.17.6.11 The System readiness review may include a desk review and/or an onsite review. If DHHS determines that it is necessary to conduct an onsite review, the MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from DHHS.

4.17.6.12 For purposes of this Section of the Agreement, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by DHHS or its authorized agent in connection with the onsite reviews.

4.17.6.13 If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by DHHS, either correct such deficiency or submit to DHHS a CAP and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, DHHS may impose contractual remedies according to the severity of the deficiency as described in Section 5.5 (Remedies) of this Agreement.

4.17.6.14 QOS metrics shall include:

4.17.6.14.1 System Integrity: The MCO system shall ensure that both user and Provider portal design, and implementation is in accordance with federal standards, regulations and guidelines related to security, confidentiality and auditing (e.g. HIPAA Privacy and Security Rules, National Institute of Security and Technology).

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4.17.6.14.2 The security of the Care Management processing system shall minimally provide the following three types of controls to maintain data integrity that directly impacts QOS. These controls shall be in place at all appropriate points of processing:

4.17.6.14.2.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.

4.17.6.14.2.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.

4.17.6.14.2.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

4.17.6.14.3 System Administration: Ability to comply with HIPAA, ADA, and other State and federal regulations, and perform in accordance with Agreement terms and conditions, ability to provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development.

4.17.6.14.4 The system shall accommodate changes with global impacts (e.g., implementation of electronic health record, e-Prescribe) as well as new transactions at no additional cost.

4.17:7 **[Amendment #5:] Interoperability and Patient Access**

4.17.7.1 [Amendment #5:] The MCO shall comply with the Centers for Medicare & Medicaid Services published final rule, "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers," (referred to as the "CMS Interoperability and Patient Access final rule") to further advance interoperability for Medicaid and Children's Health Insurance Program (CHIP) providers and improve beneficiaries' access to their data.

4.17.7.2 [Amendment #5:] The MCO shall implement this final rule in a manner consistent with existing guidance and the published "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" final rule (referred to as the ONC 21st Century Cures Act final rule), including:

4.17.7.2.1 [Amendment #5:] Patient Access Application Program Interfaces (API). [42 CFR 438.242(b)(5); 42 CFR 457.1233(d); 85

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Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)];

4.17.7.2.2 [Amendment #5:] Provider Directory Application Program Interfaces (API). [42 CFR 438.242(b)(6); 85 Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)]; and

4.17.7.2.3 [Amendment #5:] Implement and maintain a Payer-to-Payer Data Exchange. [42 CFR 438.62(b)(1)(vi)-(vii); 85 Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)].

4.17.7.3 [Amendment #8:] The MCO shall implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60 no later than July 1, 2021, and include(s):

4.17.7.3.1 [Amendment #8:] Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

4.17.7.3.2 [Amendment #8:] Encounter data, including encounter data from any network providers the MCO is compensating on the basis of capitation payments and adjudicated claims and encounter data from any Subcontractors no later than one (1) business day after receiving the data from providers;

4.17.7.3.3 [Amendment #8:] Clinical data, including laboratory results, if the MCO maintains any such data, no later than one (1) business day after the data is received by the state; and

4.17.7.3.4 [Amendment #8:] Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. [42 CFR 438.242(b)(5); 42 CFR 457.1233(d)(2)]

4.17.7.4 [Amendment #8:] The MCO shall implement and maintain a publicly accessible standards-based API no later than July 1, 2021 as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2). [42 CFR 438.242(b)(6); 42 CFR 457.1233(d)(3)]

4.18 Claims Quality Assurance Standards

4.18.1 Claims Payment Standards

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4.18.1.1 [Amendment #7] For purposes of this Section 4.18 (Claims Quality Assurance Standards), DHHS has adopted the claims definitions established by CMS and defined in Section 2.1.25 of this Agreement. [42 CFR 447.45(b)] ~~under the Medicare program, which are as follows:~~

~~4.18.1.1.1 "Clean Claim" means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and~~

~~4.18.1.1.2 "Incomplete Claim" means a claim that is denied for the purpose of obtaining additional information from the Provider.~~

4.18.1.2 Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom by its date stamp or the date an electronic claim is submitted.

4.18.1.3 The paid date is the date a payment check or EFT is issued to the service Provider [42 CFR 447.45(d)(5) - (6); 42 CFR 447.46; sections 1932(f) and 1902(a)(37)(A) of the Act]

4.18.1.4 The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

4.18.1.5 The MCO shall pay or deny ninety-five percent (95%) of Clean Claims within thirty (30) calendar days of receipt, or receipt of additional information.

4.18.1.6 The MCO shall pay ninety-nine percent (99%) of Clean Claims within ninety (90) calendar days of receipt. [42 CFR 447.46; 42 CFR 447.45(d)(2)-(3) and (d)(5)-(6); Sections 1902(a)(37)(A) and 1932(f) of the Social Security Act].

4.18.1.7 The MCO shall request all additional information necessary to process Incomplete Claims from the Provider within thirty (30) calendar days from the date of original claim receipt.

4.18.2 Claims Quality Assurance Program

4.18.2.1 The MCO shall verify the accuracy and timeliness of data reported by Providers, including data from Participating Providers the MCO is compensating through a capitated payment arrangement.

4.18.2.2 The MCO shall screen the data received from Providers for completeness, logic, and consistency [42 CFR 438.242(b)(3)(i)-(ii)].

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4.18.2.3 The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to DHHS, in accordance with Exhibit O.

4.18.2.4 As indicated in Exhibit O, reporting to DHHS shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

The MCO shall implement CAPs to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

4.18.3 Claims Financial Accuracy

4.18.3.1 Claims financial accuracy measures the accuracy of dollars paid to Providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.

4.18.3.2 The MCO shall pay ninety-nine percent (99%) of dollars accurately.

4.18.4 Claims Payment Accuracy

4.18.4.1 Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed.

4.18.4.2 The MCO shall pay ninety-seven percent (97%) of claims accurately.

4.18.5 Claims Processing Accuracy

4.18.5.1 Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed.

4.18.5.2 The MCO shall process ninety-five percent (95%) of all claims correctly.

5 OVERSIGHT AND ACCOUNTABILITY

5.1 Reporting

5.1.1 General Provisions

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5.1.1.1 As indicated throughout this Agreement, DHHS shall document ongoing MCO reporting requirements through Exhibit O and additional specifications provided by DHHS.

5.1.1.2 The MCO shall provide data, reports, and plans in accordance with Exhibit O, this Agreement, and any additional specifications provided by DHHS.

5.1.1.3 The MCO shall comply with all NHID rules for data reporting, including those related to the NH CHIS.

5.1.1.4 The MCO shall make all collected data available to DHHS upon request and upon the request of CMS. [42 CFR 438.242(b)(4)]

5.1.1.5 The MCO shall collect data on Member and Provider characteristics as specified by DHHS and on services furnished to Members through a MCIS system or other methods as may be specified by DHHS. [42 CFR 438.242(b)(2)].

5.1.1.6 The MCO shall ensure that data received from Providers are accurate and complete by:

5.1.1.6.1 Verifying the accuracy and timeliness of reported data;

5.1.1.6.2 Screening the data for completeness, logic, and consistency; and

5.1.1.6.3 Collecting service information in standardized formats to the extent feasible and appropriate. [42 CFR 438.242(b)(3)]

5.1.1.7 DHHS shall at a minimum collect, and the MCO shall provide, the following information, and the information specified throughout the Agreement and within Exhibit O, in order to improve the performance of the MCM program [42 CFR 438.66(c)(1)-(2) and (6)-(11)]:

5.1.1.7.1 Enrollment and disenrollment data;

5.1.1.7.2 Member grievance and appeal logs;

5.1.1.7.3 Medical management committee reports and minutes;

5.1.1.7.4 Audited financial and encounter data;

5.1.1.7.5 The MLR summary reports;

5.1.1.7.6 Customer service performance data;

5.1.1.7.7 Performance on required quality measures; and

5.1.1.7.8 The MCO's QAPI Plan.

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5.1.1.8 The MCO shall be responsible for preparing, submitting, and presenting to the Governor, Legislature, and DHHS a report that includes the following information, or information otherwise indicated by the State:

5.1.1.8.1 A description of how the MCO has addressed State priorities for the MCM Program, including those specified in RSA 126-AA, throughout this Agreement, and in other State statute, policies, and guidelines;

5.1.1.8.2 A description of the innovative programs the MCO has developed and the outcomes associated with those programs;

5.1.1.8.3 A description of how the MCO is addressing social determinants of health and the outcomes associated with MCO-implemented interventions;

5.1.1.8.4 A description of how the MCO is improving health outcomes in the state; and

5.1.1.8.5 Any other information indicated by the State for inclusion in the annual report.

5.1.1.9 Prior to Program Start Date and at any other time upon DHHS request or as indicated in this Agreement, DHHS shall conduct a review of MCO policies and procedures and/or other administrative documentation.

5.1.1.9.1 DHHS shall deem materials as pass or fail following DHHS review.

5.1.1.9.2 The MCO shall complete and submit a DHHS-developed attestation that attests that the policy, procedure or other documentation satisfies all applicable State and federal authorities.

5.1.1.9.3 DHHS may require modifications to MCO policies and procedures or other documentation at any time as determined by DHHS.

5.1.2 Requirements for Waiver Programs

5.1.2.1 The MCO shall provide to DHHS the data and information required for its current CMS waiver programs and any waiver programs it enters during the Term of this Agreement that require data for Members covered by the MCO. These include but are not limited to:

5.1.2.1.1 NH's Building Capacity for Transformation 1115 waiver;

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5.1.2.1.2 [Amendment #8:] Substance Use Disorder and Severe Mental Illness Institute for Mental Disease 1115 waivers (subject to CMS approval);

5.1.2.1.3 Mandatory managed care 1915b waiver; and

5.1.2.1.4 Granite Advantage 1115 waiver.

5.1.3 Encounter Data

5.1.3.1 The MCO shall submit Encounter Data in the format and content, timeliness, completeness, and accuracy as specified by DHHS and in accordance with timeliness, completeness, and accuracy standards as established by DHHS. [42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818]

5.1.3.2 All MCO encounter requirements apply to all Subcontractors. The MCO shall ensure that all contracts with Participating Providers and Subcontractors contain provisions that require all encounter records are reported or submitted in an accurate and timely fashion such that the MCO meets all DHHS reporting requirements.

5.1.3.3 The MCO shall submit to DHHS for review, during the Readiness Review process, its policies and procedures that detail the MCO's encounter process. The MCO-submitted policies and procedures shall at minimum include to DHHS's satisfaction:

5.1.3.3.1 An end-to-end description of the MCO's encounter process;

5.1.3.3.2 A detailed overview of the encounter process with all Providers and Subcontractors; and

5.1.3.3.3 A detailed description of the internal reconciliation process followed by the MCO, and all Subcontractors that process claims on the MCO's behalf.

5.1.3.4 The MCO shall, as requested by DHHS, submit updates to and revise upon request its policies and procedures that detail the MCO's encounter process.

5.1.3.5 All Encounter Data shall remain the property of DHHS and DHHS retains the right to use it for any purpose it deems necessary.

5.1.3.6 The MCO shall submit Encounter Data to the EQRO and DHHS in accordance with this Section 5.1.3 (Encounter Data) of the Agreement and to DHHS's actuaries, as requested, according to the format and specification of the actuaries.

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5.1.3.7 Submission of Encounter Data to DHHS does not eliminate the MCO's responsibility to comply with NHID rules, Chapter Ins 4000 Uniform Reporting System for Health Care Claims Data Sets.

5.1.3.8 The MCO shall ensure that encounter records are consistent with DHHS requirements and all applicable State and federal laws.

5.1.3.9 MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

5.1.3.10 The level of detail associated with encounters from Providers with whom the MCO has a capitated payment arrangement shall be the equivalent to the level of detail associated with encounters for which the MCO received and settled a FFS claim.

5.1.3.11 The MCO shall maintain a record of all information submitted by Providers on claims. All Provider-submitted claim information shall be submitted in the MCO's encounter records.

5.1.3.12 The MCO shall have a computer and data processing system, and staff, sufficient to accurately produce the data, reports, and encounter record set in formats and timelines as defined in this Agreement.

5.1.3.13 The system shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

5.1.3.14 The MCO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these data in a standardized format approved by DHHS.

5.1.3.15 The MCO shall make all collected data available to DHHS after it is tested for compliance, accuracy, completeness, logic, and consistency.

5.1.3.16 The MCO's systems that are required to use or otherwise contain the applicable data type shall conform to current and future HIPAA-based standard code sets; the processes through which the data are generated shall conform to the same standards, including application of:

5.1.3.16.1 Health Care Common Procedure Coding System (HCPCS);

5.1.3.16.2 CPT codes;

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5.1.3.16.3 International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM and International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS;

5.1.3.16.4 National Drug Codes which is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. It is maintained and distributed by HHS, in collaboration with drug manufacturers;

5.1.3.16.5 Code on Dental Procedures and Nomenclature (CDT) which is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA);

5.1.3.16.6 POS Codes which are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry;

5.1.3.16.7 Claim Adjustment Reason Codes (CARC) which explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the Provider or the patient when other insurance is involved; and

5.1.3.16.8 Reason and Remark Codes (RARC) which are used when other insurance denial information is submitted to the MMIS using standard codes defined and maintained by CMS and the NCPDP.

5.1.3.17 All MCO encounters shall be submitted electronically to DHHS or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) or at the discretion of DHHS the ANSI X12N 837 post adjudicated transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NH file format, and other proprietary file layouts as defined by DHHS.

5.1.3.18 All MCO encounters shall be submitted with MCO paid amount, or FFS equivalent, and, as applicable, the Medicare paid amount, other insurance paid amount and/or expected Member Copayment amount.

5.1.3.19 [Amendment #5:] The paid amount (or FFS equivalent) submitted with Encounter Data shall be the amount paid to Providers, not the amount paid to MCO Subcontractors or Providers of shared services within the MCO's organization, third party administrators, or capitated entities. This requirement means that, for example for pharmacy claims, the MCO paid amount shall include the amount

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paid to the pharmacy and exclude any and all fees paid by the MCO to the Pharmacy Benefit Manager. The amount paid to the MCO's PBM is not acceptable.

5.1.3.20 The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

5.1.3.21 The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

5.1.3.22 The MCO shall collect, and submit to the State's fiscal agent, Member service level Encounter Data for all Covered Services.

5.1.3.23 The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

5.1.3.24 The MCO shall conform to all current and future HIPAA-compliant standards for information exchange, including but not limited to the following requirements:

5.1.3.24.1 Batch and Online Transaction Types are as follows:

5.1.3.24.1.1. ASC X12N 820 Premium Payment Transaction;

5.1.3.24.1.2. ASC X12N 834 Enrollment and Audit Transaction;

5.1.3.24.1.3. ASC X12N 835 Claims Payment Remittance Advice Transaction;

5.1.3.24.1.4. ASC X12N 837I Institutional Claim/Encounter Transaction;

5.1.3.24.1.5. ASC X12N 837P Professional Claim/Encounter Transaction;

5.1.3.24.1.6. ASC X12N 837D Dental Claim/Encounter Transaction; and

5.1.3.24.1.7. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.24.2 Online transaction types are as follows:

5.1.3.24.2.1. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

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- 5.1.3.24.2.2. ASC X12N 276 Claims Status Inquiry;
- 5.1.3.24.2.3. ASC X12N 277 Claims Status Response;
- 5.1.3.24.2.4. ASC X12N 278/279 Utilization Review Inquiry/Response; and
- 5.1.3.24.2.5. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.25 Submitted Encounter Data shall include all elements specified by DHHS, including but not limited to those specified in the DHHS Medicaid Encounter Submission Requirements Policy.

5.1.3.26 The MCO shall submit summary reporting in accordance with Exhibit O, to be used to validate Encounter submissions.

5.1.3.27 The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by DHHS for reporting Encounters and fee- for-service claims.

5.1.3.28 Any exceptions shall be considered on a code-by-code basis after DHHS receives written notice from the MCO requesting an exception.

5.1.3.29 The MCO shall use the Provider identifiers as directed by DHHS for both Encounter and FFS submissions, as applicable.

5.1.3.30 The MCO shall provide, as a supplement to the Encounter Data submission, a Member file on a monthly basis, which shall contain appropriate Member Medicaid identification numbers, the PCP assignment of each Member, and the group affiliation and service location address of the PCP.

5.1.3.31 The MCO shall submit complete Encounter Data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

5.1.3.32 The MCO shall assign staff to participate in encounter technical work group meetings as directed by DHHS.

5.1.3.33 The MCO shall provide complete and accurate encounters to DHHS.

5.1.3.34 The MCO shall implement review procedures to validate Encounter Data submitted by Providers. The MCO shall meet the following standards:

- 5.1.3.34.1 Completeness:

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5.1.3.34.1.1. The MCO shall submit encounters that represent one hundred percent (100%) of the Covered Services provided by Participating Providers and Non-Participating Providers.

5.1.3.34.2 Accuracy:

5.1.3.34.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits. The standard shall apply to submissions of each individual batch and online transaction type.

5.1.3.34.2.2. Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

5.1.3.34.2.3. One-hundred percent (100%) of Member identification numbers shall be accurate and valid.

5.1.3.34.2.4. Ninety-eight percent (98%) of billing Provider information shall be accurate and valid.

5.1.3.34.2.5. Ninety-eight percent (98%) of servicing Provider information shall be accurate and valid.

5.1.3.34.2.6. The MCO shall submit a monthly supplemental Provider file, to include data elements as defined by DHHS, for all Providers that were submitted on encounters in the prior month.

5.1.3.34.2.7. For the first six (6) months of encounter production submissions, the MCO shall conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Data quality.

5.1.3.34.2.7.1 The end to end test shall include a review of the Provider claim to what data is in the MCO claims processing system, and the encounter file record produced for that claim.

5.1.3.34.2.7.2 The MCO shall report a pass or fail to DHHS. If the result is a fail, the MCO shall also

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submit a root cause analysis that includes plans for remediation.

5.1.3.34.2.7.3 If DHHS or the MCO identifies a data defect, the MCO shall, for six (6) months post data defect identification, conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Data quality.

5.1.3.34.2.7.4 If two (2) or more Encounter Data defects are identified within a rolling twelve (12) month period, DHHS may require the MCO to contract with an external vendor to independently assess the MCO Encounter Data process. The external vendor shall produce a report that shall be shared with DHHS.

5.1.3.34.3 Timeliness:

5.1.3.34.3.1. Encounter Data shall be submitted weekly, within fourteen (14) calendar days of claim payment.

5.1.3.34.3.2. All encounters shall be submitted, both paid and denied claims.

5.1.3.34.3.3. The MCO shall be subject to liquidated damages as specified in Section 5.5.2 (Liquidated Damages) for failure to timely submit Encounter Data, in accordance with the accuracy standards established in this Agreement.

5.1.3.34.4 Error Resolution:

5.1.3.34.4.1. For all historical encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice.

5.1.3.34.4.2. For all ongoing claim encounters, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fourteen (14) calendar days after such notice.

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5.1.3.34.4.3. If the MCO fails to comply with either error resolution timeline, DHHS shall require a CAP and assess liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.3.34.4.4. The MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by DHHS.

5.1.3.34.5 Survival:

5.1.3.34.5.1. All Encounter Data accumulated as part of the MCM program shall remain the property of DHHS and, upon termination of the Agreement, the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS and as is further described in Section 7.7.2 (Data).

5.1.4 Data Certification

5.1.4.1 All data submitted to DHHS by the MCO shall be certified by one (1) of the following:

5.1.4.1.1 The MCO's CEO;

5.1.4.1.2 The MCO's CFO; or

5.1.4.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. [42 CFR 438.604; 42 CFR 438.606(a)]

5.1.4.2 The data that shall be certified include, but are not limited to, all documents specified by DHHS, enrollment information, Encounter Data, and other information contained in this Agreement or proposals.

5.1.4.3 The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data.

5.1.4.4 The MCO shall submit the certification concurrently with the certified data and documents [42 CFR 438.604; 42 CFR 438.606].

5.1.4.5 The MCO shall submit the MCO Data Certification process policies and procedures for DHHS review during the Readiness Review process.

5.1.5 Data System Support for Quality Assurance & Performance Improvement

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5.1.5.1 The MCO shall have a data collection, processing, and reporting system sufficient to support the QAPI program requirements described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

5.1.5.2 The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of Participating Providers, Member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

5.2 Contract Oversight Program

5.2.1 The MCO shall have a formalized Contract Oversight Program to ensure that it complies with this Agreement, which at a minimum, should outline:

5.2.1.1 The specific monitoring and auditing activities that the MCO shall undertake to ensure its and its Subcontractors' compliance with certain provisions and requirements of the Agreement;

5.2.1.2 The frequency of those contract oversight activities; and

5.2.1.3 The person(s) responsible for those contract oversight activities.

5.2.2 The Contract Oversight Program shall specifically address how the MCO shall oversee the MCO's and its Subcontractor's compliance with the following provisions and requirements of the Agreement:

5.2.2.1 Section 3.12 (Privacy and Security of Members' Information);

5.2.2.2 Section 3.14 (Subcontractors);

5.2.2.3 Section 4 (Program Requirements); and

5.2.2.4 All data and reporting requirements.

5.2.3 The Contract Oversight Program shall set forth how the MCO's Chief Executive Officer (CEO)/Executive Director, Compliance Officer and Board of Directors shall be made aware of non-compliance identified through the Contract Oversight Program.

5.2.4 The MCO shall present to DHHS for review as part of the Readiness Review a copy of the Contract Oversight Program and any implementing policies.

5.2.5 The MCO shall present to DHHS for review redlined copies of proposed changes to the Contract Oversight Program and its implementing policies prior to adoption.

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5.2.6 This Contract Oversight Program is distinct from the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan discussed in Section 5.3 (Program Integrity).

5.2.7 The MCO shall promptly, but no later than thirty (30) calendar days after the date of discovery, report any material non-compliance identified through the Contract Oversight Program and submit a Corrective Action Plan to DHHS to remediate such non-compliance.

5.2.8 The MCO shall implement any changes to the Corrective Action Plan requested by DHHS.

5.3 Program Integrity

5.3.1 General Requirements

5.3.1.1 The MCO shall present to DHHS for review, as part of the Readiness Review process, a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan and shall comply with policies and procedures that guide and require the MCO and the MCO's officers, employees, agents and Subcontractors to comply with the requirements of this Section 5.3 (Program Integrity). [42 CFR 438.608]

5.3.1.2 The MCO shall present to DHHS for review redlined copies of proposed changes to the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan prior to adoption.

5.3.1.3 The MCO shall include program integrity requirements in its Subcontracts and provider application, credentialing and recredentialing processes.

5.3.1.4 The MCO is expected to be familiar with, comply with, and require compliance by its Subcontractors with all regulations and sub-regulatory guidance related to program integrity whether or not those regulations are listed below:

5.3.1.4.1 Section 1902(a)(68) of the Social Security Act;

5.3.1.4.2 42 CFR Section 438;

5.3.1.4.3 42 CFR Section 455;

5.3.1.4.4 42 CFR Section 1000 through 1008; and

5.3.1.4.5 CMS Toolkits.

5.3.1.5 The MCO shall ensure compliance with the program integrity provisions of this Agreement, including proper payments to providers or Subcontractors, methods for detection and prevention of

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fraud, waste and abuse and the MCO's and its Subcontractors' compliance with all program integrity reporting requirements to DHHS.

5.3.1.6 The MCO shall have a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan that are designed to guard against fraud, waste and abuse.

5.3.1.7 The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent and deter fraud, waste and abuse.

5.3.1.8 The MCO shall be compliant with all applicable federal and State regulations related to Medicaid program integrity. [42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008 and Section 1902(a)(68) of the Social Security Act]

5.3.1.9 The MCO shall work with DHHS on program integrity issues, and with MFCU as directed by DHHS, on fraud, waste or abuse investigations. This shall include, at a minimum, the following:

5.3.1.9.1 Participation in MCO program integrity meetings with DHHS following the submission of the monthly allegation log submitted by the MCO in accordance with Exhibit O.

5.3.1.9.2 The frequency of the program integrity meetings shall be as often as monthly.

5.3.1.9.3 Discussion at these meetings shall include, but not be limited to, case development and monitoring.

5.3.1.9.4 The MCO shall ensure Subcontractors attend monthly meetings when requested by DHHS;

5.3.1.9.5 Participation in bi-annual MCO and Subcontractor forums to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned;

5.3.1.9.6 Quality control and review of encounter data submitted to DHHS; and

5.3.1.9.7 Participation in meetings with MFCU, as determined by MFCU and DHHS.

5.3.2 Fraud, Waste and Abuse

5.3.2.1 The MCO, or a Subcontractor which has been delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain administrative and

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management arrangements or procedures designed to detect and prevent fraud, waste and abuse. [42 CFR 438.608(a)]

5.3.2.2 The arrangements or procedures shall include the following:

5.3.2.2.1 The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan that includes, at a minimum, all of the following elements:

5.3.2.2.1.1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable federal and State requirements;

5.3.2.2.1.2. Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the Agreement and who directly reports to the CEO and the Board of Directors;

5.3.2.2.1.3. Establishment of a Regulatory Compliance Committee of the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with this Agreement;

5.3.2.2.1.4. System for training and education for the Compliance Officer, the MCO's senior management, employees, and Subcontractor on the federal and State standards and requirements under this Agreement;

5.3.2.2.1.5. Effective lines of communication between the Compliance Officer and MCO's staff and Subcontractors;

5.3.2.2.1.6. Enforcement of standards through well-publicized disciplinary guidelines; and

5.3.2.2.1.7. Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination

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of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement. [42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i) - (vii)]

5.3.2.2.2 The process by which the MCO shall monitor their marketing representative activities to ensure that the MCO does not engage in inappropriate activities, such as inducements;

5.3.2.2.3 A requirement that the MCO shall report on staff termination for engaging in prohibited marketing conduct or fraud, waste and abuse to DHHS within thirty (30) business days;

5.3.2.2.4 A description of the MCO's specific controls to detect and prevent potential fraud, waste and abuse including, without limitation:

5.3.2.2.4.1. A list of automated pre-payment claims edits, including National Correct Coding Initiative (NCCI) edits;

5.3.2.2.4.2. A list of automated post-payment claims edits;

5.3.2.2.4.3. In accordance with 42 CFR 438.602(b), the MCO shall maintain edits on its claims systems to ensure in-network claims include New Hampshire Medicaid enrolled billing and rendering provider NPIs. The MCO shall amend edits on its claims systems as required by any changes in federal and State requirements for managed care billing;

5.3.2.2.4.4. At least three (3) data analytic algorithms for fraud detection specified by DHHS Program Integrity and three (3) additional data analytic algorithms as determined by the MCO for a total of at least six (6) algorithms, which should include services provided by Subcontractors. These algorithms are subject to change at least annually;

5.3.2.2.4.5. A list of audits of post-processing review of claims planned;

5.3.2.2.4.6. A list of reports on Participating Provider and Non-Participating Provider profiling used to aid program integrity reviews;

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5.3.2.2.4.7. The methods the MCO shall use to identify high-risk claims and the MCO's definition of "high-risk claims";

5.3.2.2.4.8. Visit verification procedures and practices, including sample sizes and targeted provider types or locations;

5.3.2.2.4.9. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

5.3.2.2.4.10. A method to verify, by sampling or other method, whether services that have been represented to have been delivered by Participating Providers and were received by Members and the application of such verification processes on a regular basis. The MCO may use an explanation of benefits (EOB) for such verification only if the MCO suppresses information on EOBs that would be a violation of Member confidentiality requirements for women's health care, family planning, sexually transmitted diseases, and behavioral health services [42 CFR 455.20];

5.3.2.2.4.11. Provider and Member materials identifying the MCO's fraud and abuse reporting hotline number;

5.3.2.2.4.12. Work plans for conducting both announced and unannounced site visits and field audits of Participating Providers determined to be at high risk to ensure services are rendered and billed correctly;

5.3.2.2.4.13. The process for putting a Participating Provider on and taking a Participating Provider off prepayment review, including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate;

5.3.2.2.4.14. The ability to suspend a Participating Provider's or Non-Participating Provider's payment due to credible allegation of fraud if directed by DHHS Program Integrity; and

5.3.2.2.4.15. The process by which the MCO shall recover inappropriately paid funds if the MCO discovers wasteful and/or abusive, incorrect billing trends with a

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particular Participating Provider or provider type, specific billing issue trends, or quality trends.

5.3.2.2.5 A provision for the prompt reporting of all Overpayments identified and recovered, specifying the Overpayments due to potential fraud;

5.3.2.2.6 A provision for referral of any potential Participating Provider or Non-Participating Provider fraud, waste and abuse that the MCO or Subcontractor identifies to DHHS Program Integrity and any potential fraud directly to the MFCU as required under this Agreement [42 CFR 438.608(a)(7)];

5.3.2.2.7 A provision for the MCO's suspension of payments to a Participating Provider for which DHHS determines there is credible allegation of fraud in accordance with this Agreement and 42 CFR 455.23; and

5.3.2.2.8 A provision for notification to DHHS when the MCO receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the MCM program, including the termination of the provider agreement with the MCO as detailed in Exhibit O.

5.3.2.3 The MCO and Subcontractors shall implement and maintain written policies for all employees and any Subcontractor or agent of the entity, that provide detailed information about the False Claims Act (FCA) and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Social Security Act; 42 CFR 438.608(a)(6)]

5.3.2.4 The MCO, and if required by the MCO's Subcontractors, shall post and maintain DHHS-approved information related to fraud, waste and abuse on its website, including but not limited to, provider notices, current listing of Participating Providers, providers that have been excluded or sanctioned from the Medicaid Care Management Program, any updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

5.3.3 Identification and Recoveries of Overpayments

5.3.3.1 The MCO shall maintain an effective fraud, waste and abuse-related Provider overpayment identification, Recovery and tracking process.

5.3.3.2 The MCO shall perform ongoing analysis of its authorization, utilization, claims, Provider's billing patterns, and

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encounter data to detect improper payments, and shall perform audits and investigations of Subcontractors, Providers and Provider entities.

5.3.3.3 This process shall include a methodology for a means of estimating overpayment, a formal process for documenting communication with Providers, and a system for managing and tracking of investigation findings, Recoveries, and underpayments related to fraud, waste and abuse investigations/audit/any other overpayment recovery process as described in the fraud, waste and abuse reports provided to DHHS in accordance with Exhibit O.

5.3.3.4 The MCO and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all Overpayments, specifically for the recovery of Overpayments due to fraud, waste and abuse, and for reporting and returning Overpayments as required by this Agreement. [42 CFR 438.608(d)(1)(i)]

5.3.3.5 The MCO and its subcontractors shall report to DHHS within sixty (60) calendar days when it has identified Capitation Payments or other payment amounts received are in excess to the amounts specified in this Agreement. [42 CFR 438.608(c)(3)].

5.3.3.6 DHHS may recover Overpayments that are not recovered by or returned to the MCO within sixty (60) calendar days of notification by DHHS to pursue.

5.3.3.7 This Section of the Agreement does not apply to any amount of a recovery to be retained under False Claim Act cases or through other investigations.

5.3.3.8 Any settlement reached by the MCO or its subcontractors and a Provider shall not bind or preclude the State from further action.

5.3.3.9 DHHS shall utilize the information and documentation collected under this Agreement, as well as nationally recognized information on average recovery amounts as reported by State MFCUs and commercial insurance plans for setting actuarially sound Capitation Payments for each MCO consistent with the requirements in 42 CFR 438.4.

5.3.3.10 If the MCO does not meet the required metrics related to expected fraud referrals, overpayment recoupments, and other measures set forth in this Agreement and Exhibit O, DHHS shall impose liquidated damages, unless the MCO can demonstrate good cause for failure to meet such metrics.

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5.3.4 Referrals of Credible Allegations of Fraud and Provider and Payment Suspensions

5.3.4.1 General

5.3.4.1.1 The MCO shall, and shall require any Subcontractor to, establish policies and procedures for referrals to DHHS Program Integrity Unit and the MFCU on credible allegations of fraud and for payment suspension when there is a credible allegation of fraud. [42 CFR 438.608(a)(8); 42 CFR 455.23].

5.3.4.1.2 The MCO shall complete a DHHS "Request to Open" form for any potential fraud, waste, or abuse case, including those that lead to a credible allegation of fraud. DHHS Program Integrity Unit shall have fifteen (15) business days to respond to the MCO's "Request to Open" form.

5.3.4.1.3 When the MCO or its Subcontractor has concluded that a credible allegation of fraud or abuse exists, the MCO shall make a referral to DHHS Program Integrity Unit and any potential fraud directly to MFCU within five (5) business days of the determination on a template provided by DHHS. [42 CFR 438.608(a)(7)]

5.3.4.1.4 Unless and until prior written approval is obtained from DHHS, neither the MCO nor a Subcontractor shall take any administrative action or any of the following regarding the allegations of suspected fraud:

5.3.4.1.4.1. Suspend Provider payments;

5.3.4.1.4.2. Contact the subject of the investigation about any matters related to the investigation;

5.3.4.1.4.3. Continue the investigation into the matter;

5.3.4.1.4.4. Enter into or attempt to negotiate any settlement or agreement regarding the matter; or

5.3.4.1.4.5. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

5.3.4.1.5 The MCO shall employ pre-payment review when directed by DHHS.

5.3.4.1.6 In addition, the MCO may employ pre-payment review in the following circumstances without approval:

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- 5.3.4.1.6.1. Upon new Participating Provider enrollment;
 - 5.3.4.1.6.2. For delayed payment during Provider education;
 - 5.3.4.1.6.3. For existing Providers with billing inaccuracies;
 - 5.3.4.1.6.4. Upon receipt of a credible allegation of fraud or abuse; or
 - 5.3.4.1.6.5. Upon identification from data analysis or other grounds.
- 5.3.4.1.7 If DHHS, MFCU or another law enforcement agency accepts the allegation for investigation, DHHS shall notify the MCO's Compliance Officer within two (2) business days of the acceptance notification, along with a directive to suspend payment to the affected Provider(s) if it is determined that suspension shall not impair MFCU's or law enforcement's investigation.
- 5.3.4.1.8 DHHS shall notify the MCO if the referral is declined for investigation.
- 5.3.4.1.9 If DHHS, MFCU, or other law enforcement agencies decline to investigate the fraud referral, the MCO may proceed with its own investigation and comply with the reporting requirements contained in this Section of the Agreement.
- 5.3.4.1.10 Upon receipt of notification from DHHS, the MCO shall send notice of the decision to suspend program payments to the Provider within the following timeframe:
- 5.3.4.1.10.1. Within five (5) calendar days of taking such action unless requested in writing by DHHS, the MFCU, or law enforcement to temporarily withhold such notice; or
 - 5.3.4.1.10.2. Within thirty (30) calendar days if requested by DHHS, MFCU, or law enforcement in writing to delay sending such notice.
 - 5.3.4.1.10.3. The request for delay may be renewed in writing no more than twice and in no event may the delay exceed ninety (90) calendar days.
- 5.3.4.1.11 The notice shall include or address all of the following (42 CFR 455.23(2)):

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5.3.4.1.11.1. That payments are being suspended in accordance with this provision;

5.3.4.1.11.2. Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation;

5.3.4.1.11.3. That the suspension is for a temporary period and cite the circumstances under which the suspension shall be lifted;

5.3.4.1.11.4. Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

5.3.4.1.11.5. Where applicable and appropriate, inform the Provider of any appeal rights available to the Provider, along with the Provider's right to submit written evidence for consideration by the MCO.

5.3.4.2 All suspension of payment actions under this Section of the Agreement shall be temporary and shall not continue after either of the following:

5.3.4.2.1 The MCO is notified by DHHS that there is insufficient evidence of fraud by the Provider; or

5.3.4.2.2 The MCO is notified by DHHS that the legal proceedings related to the Provider's alleged fraud are completed.

5.3.4.3 The MCO shall document in writing the termination of a payment suspension and issue a notice of the termination to the Provider and to DHHS.

5.3.4.4 The DHHS Program Integrity Unit may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

5.3.4.4.1 MFCU or other law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;

5.3.4.4.2 Other available remedies are available to the MCO, after DHHS approves the remedies that more effectively or quickly protect Medicaid funds;

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5.3.4.4.3 The MCO determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, there is no longer a credible allegation of fraud and that the suspension should be removed.

5.3.4.4.3.1. The MCO shall review evidence submitted by the Provider and submit it with a recommendation to DHHS.

5.3.4.4.3.2. DHHS shall direct the MCO to continue, reduce or remove the payment suspension within thirty (30) calendar days of having received the evidence;

5.3.4.4.4 Member access to items or services would be jeopardized by a payment suspension because of either of the following:

5.3.4.4.4.1. An individual or entity is the sole community physician or the sole source of essential specialized services in a community; or

5.3.4.4.4.2. The individual or entity serves a large number of Members within a federal HRSA designated a medically underserved area;

5.3.4.4.5 MFCU or law enforcement declines to certify that a matter continues to be under investigation; or

5.3.4.4.6 DHHS determines that payment suspension is not in the best interests of the Medicaid program.

5.3.4.5 The MCO shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

5.3.4.5.1 Details of payment suspensions that were imposed in whole or in part; and

5.3.4.5.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.

5.3.4.6 If the MCO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of fraud without good cause, and DHHS directed the MCO to suspend payments, DHHS may impose liquidated damages.

5.3.4.7 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery

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belongs exclusively to the State, and the MCO and any involved Subcontractor have no claim to any portion of such recovery.

5.3.4.8 Furthermore, the MCO is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the State for all criminal, civil and administrative action recoveries undertaken by any government entity, including but not limited to all claims the MCO or its Subcontractor(s) has or may have against any entity or individual that directly or indirectly receives funds under this Agreement, including but not limited to any health care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other Provider in the design, manufacture, Marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DME, or other health care related products or services.

5.3.4.8.1 For the purposes of this Section of the Agreement, "subrogation" means the right of any State government entity or local law enforcement to stand in the place of the MCO or client in the collection against a third party.

5.3.4.9 Any funds recovered and retained by a government entity shall be reported to the actuary to consider in the rate-setting process.

5.3.5 Investigations

5.3.5.1 The MCO and its Subcontractors shall cooperate with all State and federal agencies that investigate fraud, waste and abuse.

5.3.5.2 The MCO shall ensure its Subcontractors and any other contracted entities are contractually required to also participate fully with any State or federal agency or their contractors.

5.3.5.3 The MCO and its Subcontractors shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable State or federal agency (e.g., MFCU, DHHS, OIG, and CMS).

5.3.5.4 The MCO and its Subcontractors shall comply with any and all directives resulting from State or federal agency investigations.

5.3.5.5 The MCO and its Subcontractors shall maintain all records, documents and claim or encounter data for Members, Providers and Subcontractors who are under investigation by any State or federal agency in accordance with retention rules or until the investigation is complete and the case is closed by the investigating State or federal agency.

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5.3.5.6 The MCO shall provide any data access or detail records upon written request from DHHS for any potential fraud, waste and abuse investigation, Provider or claim audit, or for MCO oversight review.

5.3.5.6.1 The additional access shall be provided within three (3) business days of the request.

5.3.5.7 The MCO and its Subcontractors shall request a refund from a third-party payor, Provider or Subcontractor when an investigation indicates that such a refund is due.

5.3.5.7.1 These refunds shall be reported to DHHS as Overpayments.

5.3.5.8 DHHS shall conduct investigations related to suspected Provider fraud, waste and abuse cases, and reserves the right to pursue and retain recoveries for all claims (regardless of paid date) to a Provider with a paid date older than four (4) months for which the MCO has not submitted a request to open and for which the MCO continued to pursue the case. The State shall notify the MCO of any investigation it intends to open prior to contacting the Provider.

5.3.6 Reporting

5.3.6.1 Annual Fraud Prevention Report

5.3.6.1.1 The MCO shall submit an annual summary (the "Fraud Prevention Report") that shall document the outcome and scope of the activities performed under Section 5.3 (Program Integrity).

5.3.6.1.2 The annual Fraud Prevention summary shall include, at a minimum, the following elements, in accordance with Exhibit O:

5.3.6.1.2.1. The name of the person and department responsible for submitting the Fraud Prevention Report;

5.3.6.1.2.2. The date the report was prepared;

5.3.6.1.2.3. The date the report is submitted;

5.3.6.1.2.4. A description of the SIU;

5.3.6.1.2.5. Cumulative Overpayments identified and recovered;

5.3.6.1.2.6. Investigations initiated, completed, and referred;

5.3.6.1.2.7. Analysis of the effectiveness of the activities performed; and

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5.3.6.1.2.8. Other information in accordance with Exhibit O.

5.3.6.1.3 As part of this report, the MCO shall submit to DHHS the Overpayments it recovered, certified by its CFO that this information is accurate to the best of his or her information, knowledge, and belief, as required by Exhibit O. [42 CFR 438.606]

5.3.6.2 Reporting Member Fraud

5.3.6.2.1 The MCO shall notify DHHS of any cases in which the MCO believes there is a serious likelihood of Member fraud by sending a secure email to the DHHS Special Investigation Unit.

5.3.6.2.2 The MCO is responsible for investigating Member fraud, waste and abuse and referring Member fraud to DHHS. The MCO shall provide initial allegations, investigations and resolutions of Member fraud to DHHS.

5.3.6.3 Termination Report

5.3.6.3.1 The MCO shall submit to DHHS a monthly Termination Report including Providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related program integrity involuntary termination; Provider terminations for convenience; and Providers who self-terminated.

5.3.6.3.2 The report shall be completed using the DHHS template.

5.3.6.4 Other Reports

5.3.6.4.1 The MCO shall submit to DHHS demographic changes that may impact eligibility (e.g., Address, etc.).

5.3.6.4.2 The MCO shall report at least annually to DHHS, and as otherwise required by this Agreement, on their recoveries of Overpayments. [42 CFR 38.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)]

5.3.7 Access to Records, On-Site Inspections and Periodic Audits

5.3.7.1 As an integral part of the MCO's program integrity function, and in accordance with 42 CFR 455 and 42 CFR 438, the MCO shall provide DHHS program integrity staff (or its designee), real time access to all of the MCO electronic encounter and claims data (including DHHS third-party liability) from the MCO's current claims reporting system.

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5.3.7.2 The MCO shall provide DHHS with the capability to access accurate, timely, and complete data as specified in Section 4.18.2 (Claims Quality Assurance Program).

5.3.7.3 [Amendment #10:] ~~Upon request, the~~ MCO and the MCO's Providers and Subcontractors shall permit DHHS, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises at any time during normal business hours to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours.

5.3.7.4 The MCO and its Providers and Subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring or evaluation.

5.3.7.5 Copies of records and documents shall be made at no cost to the requesting agency. [42 CFR 438.3(h)]; 42 CFR 455.21(a)(2); 42 CFR 431.107(b)(2)]. A record includes, but is not limited to:

5.3.7.5.1 Medical records;

5.3.7.5.2 Billing records;

5.3.7.5.3 Financial records;

5.3.7.5.4 Any record related to services rendered, and quality, appropriateness, and timeliness of such service;

5.3.7.5.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and

5.3.7.5.6 Any record of an MCO-paid claim or encounter, or an MCO-denied claim or encounter.

5.3.7.6 Upon request, the MCO, its Provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate DHHS, MFCU or other State or federal agencies.

5.3.7.7 DHHS, CMS, MFCU, the OIG, the Comptroller General, or any other authorized State or federal agency or duly authorized representative shall be permitted to inspect the premises, physical

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facilities, and equipment where Medicaid-related activities are conducted at any time. [42 CFR 438.3(h)]

5.3.7.8 The MCO and its Subcontractors shall be subject to on-site or offsite reviews by DHHS and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests.

5.3.7.8.1 Documents shall be furnished by the MCO or its Subcontractors at the MCO's expense.

5.3.7.9 The right to inspect and audit any records or documents of the MCO or any Subcontractor shall extend for a period of ten (10) years from the final date of this Agreement's contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.3.7.10 DHHS shall conduct, or contract for the conducting of, periodic audits of the MCO no less frequently than once every three (3) years, for the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO. [42 CFR 438.602(e)]

5.3.7.10.1 This shall include, but not be limited to, any records relevant to the MCO's obligation to bear the risk of financial losses or services performed or payable amounts under the Agreement.

5.3.8 Transparency

5.3.8.1 DHHS shall post on its website, as required by 42 CFR 438.10(c)(3), the following documents and reports:

5.3.8.1.1 The Agreement;

5.3.8.1.2 The data at 42 CFR 438.604(a)(5) where DHHS certifies that the MCO has complied with the Agreement requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 CFR 438.206;

5.3.8.1.3 The name and title of individuals included in 42 CFR 438.604(a)(6) to confirm ownership and control of the MCO, described in 42 CFR 455.104, and Subcontractors as governed by 42 CFR 438.230;

5.3.8.1.4 The results of any audits, under 42 CFR 438.602(e), and the accuracy, truthfulness, and completeness of the encounter and financial data submitted and certified by MCO; and

5.3.8.1.5 Performance metrics and outcomes.

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5.4 MCM Withhold and Incentive Program

5.4.1 [Amendment #3:] Beginning July 1, 2020, DHHS shall institute a withhold arrangement through which an actuarially sound percentage of the MCO's risk adjusted Capitation Payment will be recouped from the MCO and distributed among the MCOs participating in the MCM program on the basis of meeting targets specified in the DHHS Withhold and Incentive Program Policy. .

5.4.1.1 [Amendment #3:] For the September 2019 to June 2020 contract year, DHHS shall waive the quality withhold provisions of the Agreement due to the impact of the COVID-19 Public Health Emergency. All MCOs shall receive 100% of the quality withhold.

5.4.2 [Amendment #5:] DHHS shall issue MCM Withhold and Incentive Program Guidance by August 1st each year and/or at other times as determined by DHHS. ~~[Amendment #4:] DHHS shall, as often as annually, issue MCM Withhold and Incentive Program Guidance within ninety (90) calendar days of the start of the Plan Year, by August 1st each year.~~

5.4.3 Pursuant to 42 CFR 438.6 (b)(3), this withhold arrangement shall :

5.4.3.1 [Amendment #5:] Intentionally left blank.

5.4.3.1.1 Be for a fixed period of time and performance is measured during the rating period under the Agreement in which the withhold arrangement is applied;

5.4.3.1.2 Not be renewed automatically;

5.4.3.1.3 Be made available to both public and private contractors under the same terms of performance;

5.4.3.1.4 Not condition MCO participation in the withhold arrangement on the MCO entering into or adhering to intergovernmental transfer agreements; and

5.4.3.1.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.3.2 The MCO shall not receive incentive payments in excess of five percent (5%) of the approved Capitation Payments attributable to the Members or services covered by the incentive arrangements.

5.4.3.3 Pursuant to 42 CFR 438.6(b)(2), this incentive arrangement shall:

5.4.3.3.1 Be for a fixed period of time and performance is measured during the rating period under the Agreement in which the withhold arrangement is applied;

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5.4.3.3.2 Not be renewed automatically;

5.4.3.3.3 Be made available to both public and private contractors under the same terms of performance;

5.4.3.3.4 Not condition MCO participation in the incentive arrangement on the MCO entering into or adhering to intergovernmental transfer Agreements; and

5.4.3.3.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.4 [Amendment #4:] Any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period.

5.4.4.1 [Amendment #9:] [Amendment #8:] Intentionally left blank. Insofar as the withhold incentive is capped at one hundred five percent (105%) of approved Capitation Payments, and the design of the Withhold and Incentive Program is to maintain withhold funds in the program, should there be a remaining amount in withhold funds within the program, additional incentives shall be available through performance metrics determined by the State so that all funds will be disbursed before the end of the contract term in accordance with separate guidance.

5.4.5 [Amendment #9:] [Amendment #8:] Insofar as the withhold incentive is capped at one hundred five percent (105%) of approved Capitation Payments, and the design of the Withhold and Incentive Program is to maintain withhold funds in the program for actuarial soundness, should there be a remaining amount in withhold funds within the program, additional incentives shall be available through performance metrics determined by the State so that all funds will be disbursed before the end of the contract term in accordance with separate guidance.

5.4.5.1 [Amendment #9:] Such incentives may include performance of activities in support of the Department's efforts to manage Member medical assistance eligibility redeterminations tied to the COVID-19 Public Health Emergency.

5.4.5.1.1 [Amendment #9:] [Amendment #8:] 4.10.8.1.4 The MCO shall be eligible for a SFY 2023 withhold capitation credit up to one-half percent (.5%) based on Members who have completed their redeterminations between July 1, 2022 through December 31, 2022 as described in the MCM Withhold and Incentive Program Guidance.

5.4.5.1.2 [Amendment #9:] The MCO shall be eligible for a maximum withhold capitation credit for the SFY 2023 period up to one-half percent (.5%) based on Members who have completed their

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redeterminations between January 1, 2023 through June 30, 2023 as described in the MCM Withhold and Incentive Guidance.

5.4.5.1.2.1. [Amendment #10:] The MCO shall be eligible for a maximum withhold capitation credit for the July 1, 2023 through August 31, 2024 rating period up to 0.15% based on Members who have completed their redeterminations between July 1, 2023 through October 31, 2023 as described in the MCM Withhold and Incentive Guidance.

5.4.5.1.3 [Amendment #9:] The MCO shall be eligible for additional monetary incentives from unearned withhold related to the plan's COVID-19 Public Health Emergency Member redetermination efforts as described in the MCM Withhold and Incentive Program Guidance.

5.4.5.2 [Amendment #10:] The MCO may be eligible for additional monetary incentives from the unearned withhold funds related to performance of activities to enhance care management and administrative practices including, but not limited to: fraud, waste, and abuse; medication reviews; polypharmacy; substance use disorder; and opioid treatment provider oversight and compliance as described in separate guidance.

5.5 Remedies

5.5.1 Reservation of Rights and Remedies

5.5.1.1 The Parties acknowledge and agree that a material default or breach in this Agreement shall cause irreparable injury to DHHS.

5.5.1.2 The MCO acknowledges that failure to comply with provisions of this Agreement may, at DHHS's sole discretion, result in the assessment of liquidated damages, termination of the Agreement in whole or in part, and/or imposition of other sanctions as set forth in this Agreement and as otherwise available under State and federal law.

5.5.1.3 In the event of any claim for default or breach of this Agreement, no provision of this Agreement shall be construed, expressly or by implication, as a waiver by the State to any existing or future right or remedy available by law.

5.5.1.4 Failure of the State to insist upon the strict performance of any term or condition of this Agreement or to exercise or delay the exercise of any right or remedy provided in the Agreement or by law, or the acceptance of (or payment for) materials, equipment or

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services, shall not release the MCO from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State to insist upon the strict performance of this Agreement.

5.5.1.5 In addition to any other remedies that may be available for default or breach of the Agreement, in equity or otherwise, the State may seek injunctive relief against any threatened or actual breach of this Agreement without the necessity of proving actual damages.

5.5.1.6 The State reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as a result of any threatened or actual breach.

5.5.1.7 The remedies specified in this Section of the Agreement shall apply until the failure is cured or a resulting dispute is resolved in the MCO's favor.

5.5.2 Liquidated Damages

5.5.2.1 DHHS may perform an annual review to assess if the liquidated damages set forth in Exhibit N (Liquidated Damages Matrix) align with actual damages and/or with DHHS's strategic aims and areas of identified non-compliance, and update Exhibit N (Liquidated Damages Matrix) as needed.

5.5.2.2 DHHS and the MCO agree that it shall be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event the MCO fails to maintain the required performance standards within this Section during this Agreement.

5.5.2.3 The parties agree that the liquidated damages as specified in this Agreement and set forth in Exhibit N, and as updated by DHHS, are reasonable.

5.5.2.4 Assessment of liquidated damages shall be in addition to, not in lieu of, such other remedies that may be available to DHHS.

5.5.2.5 To the extent provided herein, DHHS shall be entitled to recover liquidated damages for each day, incidence or occurrence, as applicable, of a violation or failure.

5.5.2.6 The liquidated damages shall be assessed based on the categorization of the violation or non-compliance and are set forth in Exhibit N (Liquidated Damages Matrix).

5.5.2.7 The MCO shall be subject to liquidated damages for failure to comply in a timely manner with all reporting requirements in accordance with Exhibit O.

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5.5.3 Suspension of Payment

5.5.3.1 Payment of Capitation Payments may be suspended at DHHS's sole discretion when the MCO fails:

5.5.3.1.1 To cure a default under this Agreement to DHHS's satisfaction within thirty (30) calendar days of notification;

5.5.3.1.2 To implement a CAP addressing violations or non-compliance; and

5.5.3.1.3 To implement an approved Program Management Plan.

5.5.3.2 Upon correction of the deficiency or omission, Capitation Payments shall be reinstated.

5.5.4 Intermediate Sanctions

5.5.4.1 DHHS shall have the right to impose intermediate sanctions as set forth in 42 CFR Section 438.702(a), which include:

5.5.4.1.1 Civil monetary penalties (DHHS shall not impose any civil monetary penalty against the MCO in excess of the amounts set forth in 42 CFR 438.704(c), as adjusted);

5.5.4.1.2 Temporary management of the MCO;

5.5.4.1.3 Permitting Members to terminate enrollment without cause;

5.5.4.1.4 Suspending all new enrollment;

5.5.4.1.5 Suspending payments for new enrollment; and

5.5.4.1.6 Agreement termination.

5.5.4.2 DHHS shall impose intermediate sanctions if DHHS finds that the MCO acts or fails to act as follows:

5.5.4.2.1 Fails to substantially provide Medically Necessary services to a Member that the MCO is required to provide services to by law and/or under its Agreement with DHHS.

5.5.4.2.2 DHHS may impose a civil monetary penalty of up to \$25,000 for each failure to provide services, and may also:

5.5.4.2.2.1. Appoint temporary management for the MCO,

5.5.4.2.2.2. Grant Members the right to disenroll without cause,

5.5.4.2.2.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies

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the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.2.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(1); 42 CFR 438.702(a); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.3 Imposes premiums or charges on Members that are in excess of those permitted in the Medicaid program, in which case, the State may impose a civil monetary of up to \$25,000 or double the amount of the excess charges (whichever is greater). The State may also:

5.5.4.2.3.1. Appoint temporary management to the MCO,

5.5.4.2.3.2. Grant Members the right to disenroll without cause,

5.5.4.2.3.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.3.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; [42 CFR 438.700(b)(2); 42 CFR 438.702(a); 42 CFR 438.704(c); sections 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii) of the Social Security Act]

5.5.4.2.4 Discriminates among Members on the basis of their health status or need for health services, in which case, DHHS may impose a civil monetary penalty of up to one hundred thousand dollars (\$100,000) for each determination by DHHS of discrimination. DHHS may impose a civil monetary penalty of up to fifteen thousand dollars (\$15,000) for each individual the MCO did not enroll because of a discriminatory practice, up to the one hundred thousand dollar (\$100,000) maximum. DHHS may also:

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- 5.5.4.2.4.1. Appoint temporary management to the MCO,
- 5.5.4.2.4.2. Grant Members the right to disenroll without cause,
- 5.5.4.2.4.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or
- 5.5.4.2.4.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(3); 42 CFR 438.702(a); 42 CFR 438.704(b)(2) and (3); sections 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii) & (iv) of the Social Security Act]
- 5.5.4.2.5 Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care Provider, in which case, DHHS may impose a civil monetary penalty of up to \$25,000 for each instance of misrepresentation. DHHS may also:
 - 5.5.4.2.5.1. Appoint temporary management to the MCO,
 - 5.5.4.2.5.2. Grant Members the right to disenroll without case,
 - 5.5.4.2.5.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or
 - 5.5.4.2.5.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]
- 5.5.4.2.6 Misrepresents or falsifies information that it furnishes to CMS or to DHHS, in which case, DHHS may impose a civil monetary

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penalty of up to one hundred thousand dollars (\$100,000) for each instance of misrepresentation. DHHS may also:

5.5.4.2.6.1. Appoint temporary management to the MCO,

5.5.4.2.6.2. Grant Members the right to disenroll without cause,

5.5.4.2.6.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.6.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.7 Fails to comply with the Medicare Physician Incentive Plan requirements, in which case, DHHS may impose a civil monetary penalty of up to \$25,000 for each failure to comply. DHHS may also:

5.5.4.2.7.1. Appoint temporary management to the MCO,

5.5.4.2.7.2. Grant Members the right to disenroll without cause,

5.5.4.2.7.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.7.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B);

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1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.3 DHHS shall have the right to impose civil monetary penalty of up to \$25,000 for each distribution if DHHS determines that the MCO has distributed directly, or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by DHHS or that contain false or materially misleading information. [42 CFR 438.700(c); 42 CFR 438.704(b)(1); sections 1932(e)(1)(A); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.4 DHHS shall have the right to terminate this Agreement and enroll the MCO's Members in other MCOs if DHHS determines that the MCO has failed to either carry out the terms of this Agreement or meet applicable requirements in Sections 1905(t), 1903(m), and 1905(t) 1932 of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]

5.5.4.5 DHHS shall grant Members the right to terminate MCO enrollment without cause when an MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438. [42 CFR 438.706(b) - (d); section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.4.6 DHHS shall only have the right to impose the following intermediate sanctions when DHHS determines that the MCO violated any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations:

5.5.4.6.1 Grant Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll immediately;

5.5.4.6.2 Provide notice to Members of DHHS's intent to terminate the Agreement;

5.5.4.6.3 Suspend all new enrollment, including default enrollment, after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act; and

5.5.4.6.4 Suspend payment for Members enrolled after the effective date of the sanction and until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

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5.5.4.6.5 [42 CFR 438.700; 42 CFR 438.702(a); 42 CFR 438.704; 42 CFR 438.706(b); 42 CFR 438.722(a)-(b); Sections 1903(m)(5); 1932(e) of the Social Security Act]

5.5.5 Administrative and Other Remedies

5.5.5.1 At its sole discretion, DHHS may, in addition to the other Remedies described within this Section 5.5 (Remedies), also impose the following remedies:

5.5.5.1.1 Requiring immediate remediation of any deficiency as determined by DHHS;

5.5.5.1.2 Requiring the submission of a CAP;

5.5.5.1.3 Suspending part of or all new enrollments;

5.5.5.1.4 Suspending part of the Agreement;

5.5.5.1.5 Requiring mandated trainings; and/or

5.5.5.1.6 Suspending all or part of Marketing activities for varying lengths of time.

5.5.5.2 Temporary Management

5.5.5.2.1 DHHS, at its sole discretion, shall impose temporary management when DHHS finds, through onsite surveys, Member or other complaints, financial status, or any other source:

5.5.5.2.1.1. There is continued egregious behavior by the MCO;

5.5.5.2.1.2. There is substantial risk to Members' health;

5.5.5.2.1.3. The sanction is necessary to ensure the health of the MCO's Members in one (1) of two (2) circumstances: while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the MCO. [42 CFR 438.706(a); section 1932(e)(2)(B)(i) of the Social Security Act]

5.5.5.2.2 DHHS shall impose mandatory temporary management when the MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438.

5.5.5.2.3 DHHS shall not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines, in its sole discretion, that the MCO

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can ensure the sanctioned behavior shall not reoccur. [42 CFR 438.706(b)-(d); Section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.6 Corrective Action Plan

5.5.6.1 If requested by DHHS, the MCO shall submit a CAP within five (5) business days of DHHS's request, unless DHHS grants an extension to such timeframe.

5.5.6.2 DHHS shall review and approve the CAP within five (5) days of receipt.

5.5.6.3 The MCO shall implement the CAP in accordance with the timeframes specified in the CAP.

5.5.6.4 DHHS shall validate the implementation of the CAP and impose liquidated damages if it determines that the MCO failed to implement the CAP or a provision thereof as required.

5.5.7 Publication

5.5.7.1 DHHS may publish on its website, on a quarterly basis, a list of MCOs that had remedies imposed on them by DHHS during the prior quarter, the reasons for the imposition, and the type of remedy(ies) imposed.

5.5.7.2 MCOs that had their remedies reversed pursuant to the dispute resolution process prior to the posting shall not be listed.

5.5.8 Notice of Remedies

5.5.8.1 Prior to the imposition of remedies under this Agreement, except in the instance of required temporary management, DHHS shall issue written notice of remedies that shall include, as applicable, the following:

5.5.8.1.1 A citation to the law, regulation or Agreement provision that has been violated;

5.5.8.1.2 The remedies to be applied and the date the remedies shall be imposed;

5.5.8.1.3 The basis for DHHS's determination that the remedies shall be imposed;

5.5.8.1.4 The appeal rights of the MCO;

5.5.8.1.5 Whether a CAP is being requested;

5.5.8.1.6 The timeframe and procedure for the MCO to dispute DHHS's determination.

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5.5.8.1.6.1. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

5.5.8.1.7 If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the MCO's favor. [42 CFR 438.710(a)(1)-(2)]

5.6 State Audit Rights

5.6.1 DHHS, CMS, NHID, NH Department of Justice, the OIG, the Comptroller General and their designees shall have the right to audit the records and/or documents of the MCO or the MCO's Subcontractors during the term of this Agreement and for ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.6.2 HHS, the HHS Secretary, (or any person or organization designated by either), and DHHS, have the right to audit and inspect any books or records of the MCO or its Subcontractors pertaining to:

5.6.2.1 The ability of the MCO to bear the risk of financial losses.

5.6.2.2 Services performed or payable amounts under the Agreement. [Section 1903(m)(2)(A)(iv) of the Social Security Act]

5.6.3 In accordance with Exhibit O, no later than forty (40) business days after the end of the State Fiscal Year, the MCO shall provide DHHS a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

5.6.4 The report shall assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period.

5.6.5 DHHS shall share the report with internal and external auditors of the State and federal oversight agencies. The SSAE 16 Type 2 report shall include:

5.6.5.1 Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period;

5.6.5.2 Written assertion by the MCO's management about whether:

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5.6.5.2.1 The aforementioned description fairly presents the system in all material respects;

5.6.5.2.2 The controls were suitably designed to achieve the control objectives stated in that description; and

5.6.5.2.3 The controls operated effectively throughout the specified period to achieve those control objectives.

5.6.5.3 Report of the MCO's auditor, which:

5.6.5.3.1 Expresses an opinion on the matters covered in management's written assertion; and

5.6.5.3.2 Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.

5.6.6 The MCO shall notify DHHS if there are significant or material changes to the internal controls of the MCO.

5.6.6.1 If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.

5.6.7 The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.

5.6.8 DHHS may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing CAPs and review MCO compliance with requirements and standards as specified in this Agreement.

5.6.9 The MCO shall use reasonable efforts to respond to DHHS oral and written correspondence within one (1) business day of receipt.

5.6.10 The MCO shall file annual and interim financial statements in accordance with the standards set forth below.

5.6.11 Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners, annual audited financial statements that have been audited by an independent Certified Public Accountant. [42 CFR 438.3(m)]

5.6.11.1 Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

5.6.12 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by NHID.

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5.6.13 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners.

5.7 Dispute Resolution Process

5.7.1 Informal Dispute Process

5.7.1.1 In connection with any action taken or decision made by DHHS with respect to this Agreement, within thirty (30) calendar days following the action or decision, the MCO may protest such action or decision by the delivery of a written notice of protest to DHHS and by which the MCO may protest said action or decision and/or request an informal hearing with the NH Medicaid Director ("Medicaid Director").

5.7.1.2 The MCO shall provide DHHS with a written statement of the action being protested, an explanation of its legal basis for the protest, and its position on the action or decision.

5.7.1.3 The Director shall determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s).

5.7.1.3.1 The presentation and discussion of the disputed issue(s) shall be informal in nature.

5.7.1.4 The Director shall provide written notice of the time, format and location of the presentations.

5.7.1.5 At the conclusion of the presentations, the Director shall consider all evidence and shall render a written recommendation, subject to approval by the DHHS Commissioner, as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation.

5.7.1.6 The Director may appoint a designee to hear the matter and make a recommendation.

5.7.2 Hearing

5.7.2.1 In the event of a termination by DHHS, pursuant to 42 CFR Section 438.708, DHHS shall provide the MCO with notice and a pre-termination hearing in accordance with 42 CFR Section 438.710.

5.7.2.2 DHHS shall provide written notice of the decision from the hearing.

5.7.2.3 In the event of an affirming decision at the hearing, DHHS shall provide the effective date of the Agreement termination.

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5.7.2.4 In the event of an affirming decision at the hearing, DHHS shall give the Members of the MCO notice of the termination, and shall inform Members of their options for receiving Medicaid services following the effective date of termination. [42 CFR 438.710(b); 42 CFR 438.710(b)(2)(i) - (iii); 42 CFR 438.10]

5.7.3 No Waiver

5.7.3.1 The MCO's exercise of its rights under Section 5.5.1 (Reservation of Rights and Remedies) shall not limit, be deemed a waiver of, or otherwise impact the Parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of DHHS under RSA chapter 541-A, if applicable, or any applicable provisions of the NH Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

6 FINANCIAL MANAGEMENT

6.1 Financial Standards

6.1.1 In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with NHID regulations, to include RSA Chapter 404-F, and any other relevant laws and regulations.

6.1.2 The MCO shall maintain a risk-based capital ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

6.1.3 With the exception of payment of a claim for a medical product or service that was provided to a Member, and that is in accordance with a written agreement with the Provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

6.1.3.1 Risk-based capital ratio was less than two (2) for the most recent year filing, per RSA 404-F:14 (III); and

6.1.3.2 The MCO was not in compliance with the NHID solvency requirement.

6.1.4 The MCO shall notify DHHS within ten (10) calendar days when its agreement with an independent auditor or actuary has ended and seek approval of, and the name of the replacement auditor or actuary, if any from DHHS.

6.1.5 The MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

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6.1.6 The MCO shall submit data on the basis of which DHHS has the ability to determine that the MCO has made adequate provisions against the risk of insolvency.

6.1.7 The MCO shall inform DHHS and NHID staff by phone and by email within five (5) business days of when any key personnel learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the MCO to perform under this Agreement.

6.1.7.1 [Amendment #9:] The MCO shall prohibit clawback business arrangements whereby Pharmacy Benefit Managers (PBM) reimburse network pharmacies an initial drug reimbursement amount and dispensing fee, and subsequently the PBM receives remuneration for a portion of that fee that is unreported to the Department and its actuary.

6.2 Capitation Payments

6.2.1 Capitation payments made by DHHS and retained by the MCO shall be for Medicaid-eligible Members. [42 CFR 438.3(c)(2)]

6.2.1.1 [Amendment #5:] Capitation rates for the Term through June 30, 2020 are shown in Exhibit B (Capitation Rates).

6.2.1.2 For each of the subsequent years of the Agreement, actuarially sound per Member, per month capitated rates shall be paid as calculated and certified by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

6.2.1.3 Any rate adjustments shall be subject to the availability of State appropriations.

6.2.1.4 [Amendment #6:] Capitation rates shall be based on generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board. [42 CFR 457.10]

6.2.2 In the event the MCO incurs costs in the performance of this Agreement that exceed the capitation payments, the State and its agencies are not responsible for those costs and shall not provide additional payments to cover such costs.

6.2.3 The MCO shall report to DHHS within sixty (60) calendar days upon identifying any capitation or other payments in excess of amounts provided in this Agreement. [42 CFR 438.608(c)(3)]

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6.2.4 The MCO and DHHS agree that the capitation rates in Exhibit B (Capitation Rates) may be adjusted periodically to maintain actuarial soundness as determined by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

6.2.5 The MCO shall submit data on the basis of which the State certifies the actuarial soundness of capitation rates to an MCO, including base data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

6.2.6 When requested by DHHS, the MCO shall submit Encounter Data, financial data, and other data to DHHS to ensure actuarial soundness in development of the capitated rates, or any other actuarial analysis required by DHHS or State or federal law.

6.2.7 The MCO's CFO shall submit and concurrently certify to the best of his or her information, knowledge, and belief that all data and information described in 42 CFR 438.604(a), which DHHS uses to determine the capitated rates, is accurate. [42 CFR 438.606]

6.2.8 The MCO has responsibility for implementing systems and protocols to maximize the collection of TPL recoveries and subrogation activities. The capitation rates are calculated net of expected MCO recoveries.

6.2.9 DHHS shall make a monthly payment to the MCO for each Member enrolled in the MCO's plan as DHHS currently structures its capitation payments.

6.2.9.1 [Amendment #6:] Beginning contract year July 1, 2021, Specifically, the monthly capitation payments for all standard Medicaid Members shall be made retrospectively with a one month three month plus five (5) business day lag as soon as DHHS system modifications can be completed (for example, coverage for September 1, 2021 July 1, 2019 shall be paid by the 5th business day in October 2021 2019).

6.2.9.2 Capitation payments for all Granite Advantage Members shall be made before the end of each month of coverage.

6.2.10 Capitation rate cell is determined based on the Member characteristics as of the earliest date of Member plan enrollment span(s) within the month.

6.2.11 Capitation rate does not change during the month, regardless of Member changes (e.g., age), unless the Member's plan enrollment is terminated and the Member is re-enrolled resulting in multiple spans within the month.

6.2.12 The capitation rates shall be risk adjusted for purposes of this Agreement in an actuarially sound manner on a quarterly basis and certified by DHHS' actuary.

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6.2.12.1 [Amendment #10:] [Amendment #8:] [Amendment #6:] [Amendment #5:] The September 2019 to August 31, 2024 June 2024 2022 2023 capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.

~~[Amendment #2:] The September 2019 to June 2020 capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.~~

6.2.12.1.1 [Amendment #5:] [Amendment #2:] The risk adjustment process shall use the most recent version of the CDPS+Rx model to assign scored individuals to a demographic category and disease categories based on their medical claims and drug utilization during the study period. The methodology shall also incorporate a custom risk weight related to the cost of opioid addiction services. Scored individuals are those with at least six months of eligibility and claims experience in the base data. The methodology shall exclude diagnosis codes related to radiology and laboratory services to avoid including false positive diagnostic indicators for tests run on an individual. Additionally, each scored member with less than 12 months of experience in the base data period shall also be assigned a durational adjustment to compensate for missing diagnoses due to shorter enrollment durations; similar to a missing data adjustment.

6.2.12.1.2 [Amendment #2:] Each unscored member shall be assigned a demographic-only risk weight instead of receiving the average risk score for each MCO's scored members in the same rate cell. The risk adjustment methodology shall also incorporate a specific adjustment to address cost and acuity differences between the scored and unscored populations, which shall be documented by a thorough review of historical data for those populations based on generally accepted actuarial techniques.

6.2.12.1.3 [Amendment #2:] Members shall be assigned to MCOs and rate cells using the actual enrollment by MCO in each quarter to calculate risk scores in order to capture actual membership growth for each MCO.

6.2.12.1.4 [Amendment #5:] The capitation rates for the Non-Medically Frail population shall use an actuarially sound concurrent risk adjustment model to adjust the rates for each participating MCO until sufficient historical data is available to use a prospective risk adjustment model.

6.2.12.1.4.1. [Amendment #7:] Effective January 1, 2021, risk adjustment for the Non-Medically Frail

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population shall be performed on a prospective basis as described in this Section 6.2.12.1.

6.2.12.2 ~~[Amendment #9:]~~~~[Amendment #8:]~~ Intentionally left blank. For the period July 1, 2022 through June 30, 2023, capitation rates shall be subject to a retroactive acuity adjustment methodology to account for the change in enrollment during the public health emergency continuous enrollment unwind as authorized in writing by the Centers for Medicare and Medicaid Services Division of Managed Care Policy on May 11, 2022, and described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for this Amendment #8.

6.2.12.3 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024 capitation rates include a preliminary acuity adjustment based on DHHS's intended PHE unwind process and a detailed redetermination schedule to estimate the percentage of Members expected to leave the Medicaid program for each redetermination cohort as explained in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for this rating period Amendment. The adjustment will be updated for Amendment #11 capitation rates, as appropriate.

6.2.13 DHHS reserves the right to terminate or implement the use of a risk adjustment process for all or specific eligibility categories or services if it is determined to be necessary to do so to maintain actuarially sound rates or as a result of credibility considerations of a population's size as determined by DHHS's actuary.

6.2.14 Capitation adjustments are processed systematically each month by DHHS's MMIS.

6.2.15 DHHS shall make systematic adjustments based on factors that affect rate cell assignment or plan enrollment.

6.2.16 If a Member is deceased, DHHS shall recoup any and all capitation payments after the Member's date of death including any prorated share of a capitation payment intended to cover dates of services after the Member's date of death.

6.2.17 DHHS shall also make manual adjustments as needed, including manual adjustments for kick payments.

6.2.18 DHHS has sole discretion over the settlement process.

6.2.19 The MCO shall follow policies and procedures for the settlement process as developed by DHHS.

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6.2.20 Based on the provisions herein, DHHS shall not make any further retroactive adjustments other than those described herein or elsewhere in this agreement.

6.2.21 DHHS and the MCO agree that there is a nine (9) month limitation from the date of the capitation payment and is applicable only to retroactive capitation rate payments described herein, and shall in no way be construed to limit the effective date of enrollment in the MCO.

6.2.22 DHHS shall have the discretion to recoup payments retroactively up to twenty-four (24) months for Members whom DHHS later determines were not eligible for Medicaid during the enrollment month for which capitation payment was made.

6.2.23 For each live birth, DHHS shall make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.23.1 This payment is a global fee to cover all delivery care.

6.2.23.2 In the event of a multiple birth DHHS shall only make only one (1) maternity kick payment.

6.2.23.3 A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

6.2.24 For each live birth, DHHS shall make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.24.1 This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services.

6.2.24.2 For example, the newborn kick payment shall cover all services provided in July 2019 and August 2019 for a baby born any time in July 2019.

6.2.24.3 Enrolled babies shall be covered under the MCO capitated rates thereafter.

6.2.25 Different rates of newborn kick payments may be employed by DHHS, in its sole discretion, to increase actuarial soundness.

6.2.25.1 [Amendment #1:] For the period beginning September 1, 2019, two (2) newborn kick payments shall be employed, one (1) for newborns with NAS and one (1) for all other newborns. [Base Contract:] For the period beginning July 1, 2019, two (2) newborn kick payments shall be employed, one (1) for newborns with NAS and one (1) for all other newborns.

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6.2.25.2 Each type of payment is distinct and only one payment is made per newborn.

6.2.26 The MCO shall submit information on maternity and newborn events to DHHS, and shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

6.2.27 Payment for behavioral health rate cells shall be determined based on a Member's CMH Program or CMH Provider behavioral certification level as supplied in an interface to DHHS's MMIS by the MCO.

6.2.27.1 The CMH Program or CMH Provider behavioral certification level is based on a Member having had an encounter in the last six (6) months.

6.2.27.2 Changes in the certification level for a Member shall be reflected as of the first of each month and does not change during the month.

6.2.28 [Amendment #1:] Beginning September 1, 2019, after the completion of each Agreement year, an actuarially sound withhold percentage of each MCO's risk adjusted capitation payment net of directed payments to the MCO shall be calculated as having been withheld by DHHS. On the basis of the MCO's performance, as determined under DHHS's MCM Withhold and Incentive Guidance, unearned withhold in full or in part is subject to recoupment by DHHS to be used to finance an MCO incentive pool.
~~[Base Contract:] Beginning July 1, 2019, after the completion of each Agreement year, an actuarially sound withhold percentage of each MCO's risk adjusted capitation payment net of directed payments to the MCO shall be calculated as having been withheld by DHHS. On the basis of the MCO's performance, as determined under DHHS's MCM Withhold and Incentive Guidance, unearned withhold in full or in part is subject to recoupment by DHHS to be used to finance an MCO incentive pool.~~

6.2.29 Details of the MCM Withhold and Incentive Program are described in MCM Withhold and Incentive Program Guidance provided by DHHS as indicated in Section 5.4 (MCM Withhold and Incentive Payment Program).

6.2.30 DHHS shall inform the MCO of any required program revisions or additions in a timely manner.

6.2.31 DHHS may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

6.2.32 In the event an enrolled Medicaid Member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive the applicable capitation payment for that Member.

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6.2.33 The entity responsible for coverage of the Member at the time of admission as an inpatient (either DHHS or another MCO) shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

6.2.34 [Amendment #8:] Beginning July 1, 2022, DHHS shall only make a monthly capitation payment to the MCO for a Member aged 21–64 receiving inpatient treatment in an IMD, as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment, or as has been otherwise permitted by CMS through a waiver obtained from CMS. [42 CFR 438.6(e)]

6.2.35 Unless MCOs are exempted, through legislation or otherwise, from having to make payments to the NH Insurance Administrative Fund (Fund) pursuant to RSA 400-A:39, DHHS shall reimburse MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NHID.

6.2.36 [Amendment #5:] [Amendment #2:] For any Member with claims exceeding five hundred thousand dollars (\$500,000) or other attachment point described in this section for the fiscal year, after applying any third party insurance offset, DHHS shall reimburse fifty percent (50%) of the amount over the greater of five hundred thousand dollars (\$500,000) or the attachment point after all claims have been recalculated based on the DHHS fee schedule for the services and pro-rated for the contract year, as appropriate.

6.2.36.1 [Amendment #5:] The stop-loss attachment point of \$500,000 shall be indexed annually at a rate of 3.0% from its inception in SFY 2016 and rounded to the nearest \$1,000.

6.2.36.1.1 [Amendment #5:] For the period July 1, 2020 through June 30, 2021, the attachment point shall be \$580,000.

6.2.36.1.2 [Amendment #6:] For the period July 1, 2021 through June 30, 2022, the attachment point shall be \$597,000.

6.2.36.1.3 [Amendment #8:] For the period July 1, 2022 through June 30, 2023, the attachment point shall be \$615,000.

6.2.36.1.4 [Amendment #10:] For the period July 1, 2023 through August 31, 2024, the attachment point shall be \$740,000.

6.2.36.2 [Amendment #5:] For a Member whose services may be projected to exceed the attachment point five hundred thousand

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dollars ~~(\$500,000)~~ in total MCO claims, the MCO shall advise DHHS in writing.

6.2.36.3 [Amendment #5:] Prior approval from the Medicaid Director is required for subsequent services provided to the Member.

6.2.36.4 [Amendment #5:] ~~[Amendment #2:] 6.2.36.1.1~~ Hospital inpatient and hospital outpatient services provided by Boston Children's Hospital are exempt from stop-loss protections referenced in this section.

6.2.37 [Amendment #2:] DHHS shall implement a budget neutral-risk pool for services provided at Boston Children's Hospital in order to better allocate funds based on MCO-specific spending for these services. Inpatient and outpatient facility services provided at Boston Children's Hospital qualify for risk pool calculation.

6.2.38 [Amendment #2:] Beginning September 1, 2019, the gene therapy medication Zolgensma used to treat spinal muscular atrophy (SMA) shall be carved-out of the at-risk services under the MCM benefit package. As such, costs for Zolgensma and other carved-out medications shall not be considered under the various risk mitigation provisions of the Agreement.

6.2.38.1 [Amendment #5:] For the contract period January 1, 2021 through June 30, 2021, the cost of the COVID-19 vaccine and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

6.2.38.2 [Amendment #10:] [Amendment #8:] [Amendment #6:] For the contract period July 1, 2023~~2024~~ through August 31, 2024~~the end of the federal Public Health Emergency Period June 30, 2022~~, the cost of the COVID-19 vaccines and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

6.2.38.3 [Amendment #8:] For the contract period July 1, 2022 through June 30, 2023, the cost of COVID vaccine counseling for children and youth ages 0 up to 21 years shall be under a non-risk payment arrangement as further described in guidance.

6.2.38.4 [Amendment #9:] Beginning January 1, 2023, high cost gene therapy and biological medications shall be under a non-risk payment arrangement and excluded under the various risk mitigation provisions of the Agreement as described in separate guidance.

6.2.39 [Amendment #4:] Beginning September 1, 2019, should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which

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CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. [Amendment #3:] Beginning September 1, 2019, should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must not implement that part after the effective date of the loss of program authority.

6.2.39.1 [Amendment #4:] The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. [Amendment #3:] The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law.

6.2.39.2 [Amendment #4:] If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work. [Amendment #3:] If the MCO received capitation payments that included costs specific to a program or activity no longer authorized by law prior to the effective date of the loss of authority for work that would be performed after that effective date, the state must adjust those capitation payments to ensure that previous reimbursement of costs specific to the program or activity no longer authorized is returned to the state and that costs specific to the program or activity no longer authorized are no longer paid by the state after the effective date of the loss of program authority.

6.2.39.3 [Amendment #4:] If the state paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. [Amendment #3:] Capitation payments received prior to the effective date of loss of program authority that included costs for work specific to the program or activity that is no longer authorized, but that was performed prior to that effective date, may be retained by the managed care plan and need not be returned to the state.

6.2.39.4 [Amendment #4:] However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

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6.2.40 [Amendment #4:] To account for attributable costs related to the HB 4 January 2021 provider rate increase and unknown development of COVID-19 costs, a January 2021 rate refresh shall be conducted.

6.2.41 [Amendment #10:] [Amendment #8:] For the July 1, 20232022 through August 31, 2024June 30, 2023 rating period, DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG codes 880-887, except as described in Section 6.2.41.3 below.

[Amendment #7:] For the July 1, 2021 through June 30, 2022 rating period, DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG code 880-887, and the State Plan rate for Hampstead Hospital.

6.2.41.1 [Amendment #6:] The kick payment shall be specific to the corresponding Peer Groups established by DHHS. Separate kick payments exist for Peer Group 01 and 07, Peer Group 02, Peer Group 06, and Peer Group 09.

6.2.41.2 [Amendment #6:] Psychiatric admissions for dually eligible Members are not subject to the kick payment and shall be paid out of the capitation rates.

6.2.41.3 [Amendment #8:] [Amendment #6:] Psychiatric admissions for adult Members at New Hampshire Hospital and Hampstead Hospital are not subject to the kick payment and shall be paid out of the MCO's capitation rates.

6.2.42 [Amendment #7:] Intentionally left blank [Amendment #6:] Effective July 1, 2021, DHHS shall initially pay capitation rates based on the December 2021 Public Health Emergency (PHE) scenario of the PHE ending December 2021 or later.

6.2.42.1 [Amendment #7:] Intentionally left blank [Amendment #6:] In the event the PHE ends prior to October 1, 2021, DHHS shall retroactively pay capitation rates developed under the September 2021 scenario as described in the actuarial rate report for the period July 1, 2021 through June 30, 2022.

6.3 [Amendment #6:] Medical Loss Ratio Reporting and Settlement

6.3.1 Minimum Medical Loss Ratio Performance and Rebate Requirements

6.3.1.1 The MCO shall meet a minimum MLR of eighty-five percent (85%) or higher.

6.3.1.2 In the event the MCO's MLR for any single reporting year is below the minimum of the eighty-five percent (85%) requirement, the MCO shall provide to DHHS a rebate, no later than sixty (60)

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calendar days following DHHS notification, that amounts to the difference between the total amount of Capitation Payments received by the MCO from DHHS multiplied by the required MLR of eighty-five percent (85%) and the MCO's actual MLR. [42 CFR 438.8(j); 42 CFR 438.8(c)]

6.3.1.3 If the MCO fails to pay any rebate owed to DHHS in accordance with the time periods set forth by DHHS, in addition to providing the required rebate to DHHS, the MCO shall pay DHHS interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher, on the total amount of the rebate.

6.3.2 Calculation of the Medical Loss Ratio

6.3.2.1 The MCO shall calculate and report to DHHS the MLR for each MLR reporting year, in accordance with 42 CFR 438.8 and the standards described within this Agreement. [42 CFR 438.8(a)]

6.3.2.2 The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)). [42 CFR 438.8 (d)-(f)].

6.3.2.3 Each MCO expense shall be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense shall be pro-rated between the two types of expenses.

6.3.2.3.1 Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on a pro rata basis. [42 CFR 438.8(g)(1)(i)-(ii)]

6.3.2.4 Expense allocation shall be based on a generally accepted accounting method that is extended to yield the most accurate results.

6.3.2.4.1 Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

6.3.2.4.2 Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to other entities. [42 CFR 438.8(g)(2)(i)-(iii)]

6.3.2.5 The MCO may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

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6.3.2.5.1 The credibility adjustment, if included, shall be added to the reported MLR calculation prior to calculating any remittances.

6.3.2.5.2 The MCO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

6.3.2.5.3 If the MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. [42 CFR 438.8(h)(1)-(3)]

6.3.3 Medical Loss Ratio Reporting

6.3.3.1 The MCO shall submit MLR summary reports quarterly to DHHS in accordance with Exhibit O [42 CFR 438.8(k)(2); 42 CFR 438.8(k)(1)].

6.3.3.2 The MLR summary reports shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year, including:

6.3.3.2.1 Total incurred claims;

6.3.3.2.2 Expenditures on quality improvement activities;

6.3.3.2.3 Expenditures related to activities compliant with the program integrity requirements;

6.3.3.2.4 Non-claims costs;

6.3.3.2.5 Premium revenue;

6.3.3.2.6 Taxes;

6.3.3.2.7 Licensing fees;

6.3.3.2.8 Regulatory fees;

6.3.3.2.9 Methodology(ies) for allocation of expenditures;

6.3.3.2.10 Any credibility adjustment applied;

6.3.3.2.11 The calculated MLR;

6.3.3.2.12 Any remittance owed to the State, if applicable;

6.3.3.2.13 A comparison of the information reported with the audited financial report;

6.3.3.2.14 A description of the aggregate method used to calculate total incurred claims; and

6.3.3.2.15 The number of Member months. [42 CFR 438.8(k)(1)(i)-(xiii); 42 CFR 438.608(a)(1)-(5); 42 CFR 438.608(a)(7)-(8); 42 CFR 438.608(b); 42 CFR 438.8(i)]

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6.3.3.3 The MCO shall attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to DHHS. [42 CFR 438.8(n); 42 CFR 438.8(k)]

6.3.3.4 Such summary reports shall be based on a template developed and provided by DHHS within sixty (60) calendar days of the Program Start Date. [42 CFR 438.8(a)]

6.3.3.5 The MCO shall in its MLR summary reports aggregate data for all Medicaid eligibility groups covered under this Agreement unless otherwise required by DHHS. [42 CFR 438.8(i)]

6.3.3.6 The MCO shall require any Subcontractor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCO within one hundred and eighty (180) calendar days or the end of the MLR reporting year or within thirty (30) calendar days of a request by the MCO, whichever comes sooner, regardless of current contract limitations, to calculate and validate the accuracy of MLR reporting. [42 CFR 438.8(k)(3)]

6.3.3.7 In any instance in which DHHS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to DHHS, the MCO shall:

6.3.3.7.1 Re-calculate the MLR for all MLR reporting years affected by the change; and

6.3.3.7.2 Submit a new MLR report meeting the applicable requirements. [42 CFR 438.8(m); 42 CFR 438.8(k)]

6.3.3.8 The MCO and its Subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

6.3.4 [Amendment #6:] Minimum and Maximum Medical Loss Ratios

6.3.4.1 [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] For the period July 1, ~~2023~~2024 through August 31, 2024 ~~June 30, 2022-2023~~, the target MLR for at-risk services is ~~90.98%~~90.8% for Standard Medicaid and ~~89.9%~~90.21% for GAHCP based on the ~~SFY 2023~~ projected enrollment distribution for the rating period. Please note, each program's target MLR may change in future rate amendments as a result of changes to underlying assumptions, such as enrollment projections, emerging utilization experience, and ~~the retroactive acuity adjustments, if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.~~ The minimum MLR is set on a program wide basis for each major

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population, such that the maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs below: shall limit the MCO's gain to four percent (4%). The maximum MLR shall limit the MCO's loss to two three and one half percent (3.5-2.5%) over the target MLR.

6.3.4.1.1 [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] The minimum MLR is set on a program-wide basis for each major population, such that the maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). The minimum MLR shall be ~~88.2~~ 88.343% for the Standard Medicaid population and ~~87.4~~ 87.476% for the GAHCP population.

6.3.4.1.2 [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCOs will have a maximum loss of 2.0%. Based on the target MLRs, the maximum MLR shall be ~~94.343%~~ 94.2 ~~94.3%~~ for the Standard Medicaid population and ~~93.4~~ 93.476% for the GAHCP population.

6.3.4.1.2.1. [Amendment #9] [Amendment #8:] The final maximum and minimum MLRs for Standard Medicaid and GAHCP shall be updated for the final retroactive acuity factor and any other changes implemented in the ~~expected January 2023~~ contract amendment, as applicable.

6.3.4.1.3 [Amendment #6:] The settlement shall be done separately for the Standard Medicaid and GAHCP populations.

6.3.4.1.4 [Amendment #9:] [Amendment #8:] [Amendment #6:] Other MCM program risk mitigation provisions shall apply prior to the minimum and maximum MLR calculation ~~risk corridor~~ (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, ~~and~~ prospective risk adjustment, and retrospective acuity adjustment), if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

6.3.4.1.5 [Amendment #8:] [Amendment #6:] The numerator of the MCO's actual MLR shall include all payments made to providers, such as fee-for-service payments, sub-capitation payments, incentive payments, and settlement payments. The numerator of

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each MCO's actual MLR shall not include costs related to quality improvement expenses or fraud, waste and abuse prevention.

6.3.4.1.6 [Amendment #6:] Payments and revenue related to directed payments and premium taxes shall be excluded from the numerator and denominator of the MCO's actual MLR.

6.3.4.1.7 [Amendment #6:] Any incentive payments made to higher-performing MCOs as part of the Withhold Program shall not impact the minimum or maximum MLR provision of the contract.

6.3.4.1.8 [Amendment #6:] The timing of the minimum and maximum MLR settlement shall occur after the contract year is closed and substantial paid claims runout is available.

6.3.4.1.8.1. [Amendment #8:] Payments related to the Withhold and Incentive Program shall be excluded from the minimum and maximum MLR settlement.

6.4 Financial Responsibility for Dual-Eligible Members

6.4.1 [Amendment #7:] For Medicare Part A crossover claims and Medicare Part B crossover claims billed on the UB-04, the MCO shall pay the patient responsibility amount (deductible and coinsurance) for covered services. For the period July 1, 2021 through June 30, 2022, the minimum MLR shall limit the MCO's gain to four percent (4%). The maximum MLR shall limit the MCO's loss to three and one-half percent (3 1/2%) over the target MLR.

6.4.2 For Part B crossover claims billed on the CMS-1500, the MCO shall pay the lesser of:

6.4.2.1 [Amendment #7:] The patient responsibility amount (deductible and coinsurance) for covered services, or

6.4.2.2 The difference between the amount paid by the primary payer and the Medicaid allowed amount.

6.4.3 For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO shall make no payment.

6.5 Medical Cost Accruals

6.5.1 The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims, services rendered for which claims have not been received.

6.6 Audits

6.6.1 The MCO shall permit DHHS or its designee(s) and/or the NHID to inspect and audit any of the financial records of the MCO and its Subcontractors.

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6.6.2 There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. [42 CFR 438.6(g), SMM 2087.7; 42 CFR 434.6(a)(5)]

6.6.3 The MCO shall file annual and interim financial statements in accordance with the standards set forth in this Section 6 (Financial Management) of this Agreement.

6.6.3.1 This Section shall supersede any conflicting requirements in Exhibit C (Special Provisions) of this Agreement.

6.6.4 Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the NAIC, annual audited financial statements that have been audited by an independent Certified Public Accountant.

6.6.4.1 Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

6.6.5 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the NHID.

6.6.6 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

6.7 Member Liability

6.7.1 The MCO shall not hold MCM Members liable for:

6.7.1.1 The MCO's debts, in the event of the MCO's insolvency;

6.7.1.2 The Covered Services provided to the Member, for which the State does not pay the MCO;

6.7.1.3 The Covered Services provided to the Member, for which the State, or the MCO does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement; or

6.7.1.4 Payments for Covered Services furnished under an agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the MCO provided those services directly. [42 CFR 438.106(a)-(c);

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section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230]

6.7.2 The MCO shall provide assurances satisfactory to DHHS that its provision against the risk of insolvency is adequate to ensure that Medicaid Members shall not be liable for the MCO's debt if the MCO becomes insolvent. [42 CFR 438.116(a)]

6.7.3 Subcontractors and Referral Providers may not bill Members any amount greater than would be owed if the entity provided the services directly [Section 1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; 42 CFR 438.204(a); SMDL 12/30/97].

6.7.4 The MCO shall cover services to Members for the period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency. [SMM 2086.6B]

6.7.5 The MCO shall meet DHHS's solvency standards for private health maintenance organizations, or be licensed or certified by DHHS as a risk-bearing entity. [Section 1903(m)(1) of the Social Security Act; 42 CFR 438.116(b)]

6.8 Denial of Payment

6.8.1 Payments provided for under the Agreement shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS.

6.8.2 CMS may deny payment to the State for new Members if its determination is not timely contested by the MCO. [42 CFR 438.726(b); 42 CFR 438.730(e)(1)(ii)]

6.9 Federal Matching Funds

6.9.1 Federal matching funds are not available for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services. [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and Section 1903(i)(2) of the SSA; SMDL 12/30/97]

6.9.2 Payments made to such Providers are subject to recoupment from the MCO by DHHS.

6.10 Health Insurance Providers Fee

6.10.1 The Affordable Care Act imposed an annual fee on health insurance Providers beginning in 2014 ("Annual Fee").

6.10.1.1 [Amendment #6:] The Further Consolidated Appropriations Act, 2020, repealed the annual fee on health insurance Providers for calendar years beginning after December 31, 2020; therefore, calendar year 2020 shall be the last fee year.

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6.10.2 The MCO is responsible for a percentage of the Annual Fee for all health insurance Providers as determined by the ratio of MCO's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

6.10.3 To the extent such fees exist and DHHS is legally obligated to pay such fees under Federal law:

6.10.3.1 The State shall reimburse the MCO for the amount of the Annual Fee specifically allocable to the premiums paid during the Term of this Agreement for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee").

6.10.3.2 The MCO's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount the MCO or the MCO's parent receives from the United States Internal Revenue Service.

6.10.3.3 The State shall provide reimbursement no later than one hundred and twenty (120) business days following its review and acceptance of the MCO's Adjusted Fee.

6.10.3.4 To claim reimbursement for the MCO's Adjusted Fee, the MCO shall submit a certified copy of its full Annual Fee assessment within sixty (60) business days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Agreement.

6.10.3.5 The MCO shall also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums, and any other data deemed necessary by the State to validate the reimbursement amount.

6.10.3.6 These materials shall be submitted under the signatures of either its Financial Officer or CEO/Executive Director, certifying the accuracy, truthfulness and completeness of the data provided.

6.11 Third Party Liability

6.11.1 NH Medicaid shall be the payor of last resort for all Covered Services in accordance with federal regulations.

6.11.2 The MCO shall develop and implement policies and procedures to meet its obligations regarding TPL. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.3 DHHS and the MCO shall cooperate in implementing cost avoidance and cost recovery activities.

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6.11.4 The MCO shall be responsible for making every reasonable effort to determine the liable third party to pay for services rendered and cost avoid and/or recover any such liabilities from the third party.

6.11.5 DHHS shall conduct two (2) TPL policy and procedure audits of the MCO and its Subcontractors per Agreement year.

6.11.5.1 Noncompliance with CAPs issued due to deficiencies may result in liquidated damages as outlined in Exhibit N.

6.11.6 The MCO shall have one (1) dedicated contact person for DHHS for TPL.

6.11.7 DHHS and/or its actuary shall identify a market-expected median TPL percentage amount and deduct an appropriate amount from the gross medical costs included in the DHHS Capitation Payment rate setting process.

6.11.8 All cost recovery amounts, even those greater than identified in the rate cells, shall be retained by the MCO.

6.11.9 The MCO and its Subcontractors shall comply with all regulations and State laws related to TPL, including but not limited to:

6.11.9.1 42 CFR 433.138;

6.11.9.2 42 CFR 433.139; and

6.11.9.3 RSA 167:14-a.

6.11.10 Cost Avoidance

6.11.10.1 The MCO and its Subcontractors performing claims processing duties shall be responsible for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources, including but not limited to Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1396a(a)(25) plans and workers compensation.

6.11.10.2 The MCO shall establish claims edits and deny payment of claims when active Medicare or active private insurance exists at the time the claim is adjudicated and the claim does not reflect payment from the other payer.

6.11.10.3 The MCO shall deny payment on a claim that has been denied by Medicare or private insurance when the reason for denial is the Provider or Member's failure to follow prescribed procedures including, but not limited to, failure to obtain Prior Authorization or timely claim filing.

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6.11.10.4 The MCO shall establish claim edits to ensure claims with Medicare or private insurance denials are properly denied by the MCO.

6.11.10.5 The MCO shall make its own independent decisions about approving claims for payment that have been denied by the private insurance or Medicare if either:

6.11.10.5.1 The primary payor does not cover the services and the MCO does; or

6.11.10.5.2 The service was denied as not Medically Necessary and the Provider followed the dispute resolution and/or Appeal Process of the private insurance or Medicare and the denial was upheld.

6.11.10.6 If a claim is denied by the MCO based on active Medicare or active private insurance, the MCO shall provide the Medicare or private insurance information to the Provider.

6.11.10.7 To ensure the MCO is cost avoiding, the MCO shall implement a file transfer protocol between DHHS MMIS and the MCO's MCIS to receive and send Medicare and private insurance information and other information as required pursuant to 42 CFR 433.138.

6.11.10.8 The MCO shall implement a nightly file transfer protocol with its Subcontractors to ensure Medicare, private health insurance, ERISA, 29 U.S.C. 1396a(a)(25) plans, and workers compensation policy information is updated and utilized to ensure claims are properly denied for Medicare or private insurance.

6.11.10.9 The MCO shall establish, and shall ensure its Subcontractors utilize, monthly electronic data matches with private insurance companies (Medical and pharmacy) that sell insurance in the State to obtain current and accurate private insurance information for their Members. This provision may be satisfied by a contract with a third-party vendor to the MCO or its Subcontractors. Notwithstanding the above, the MCO remains solely responsible for meeting the requirement.

6.11.10.10 Upon audit, the MCO shall demonstrate with written documentation that good faith efforts were made to establish data matching agreements with insurers selling in the State who have refused to participate in data matching agreements with the MCO.

6.11.10.11 The MCO shall maintain the following private insurance data within their system for all insurance policies that a Member may have and include for each policy:

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- 6.11.10.11.1. Member's first and last name;
- 6.11.10.11.2. Member's policy number;
- 6.11.10.11.3. Member's group number, if available;
- 6.11.10.11.4. Policyholder's first and last name;
- 6.11.10.11.5. Policy coverage type to include at a minimum:
 - 6.11.10.11.5.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below).
 - 6.11.10.11.5.2. Hospital coverage,
 - 6.11.10.11.5.3. Pharmacy coverage,
 - 6.11.10.11.5.4. Dental coverage, and
 - 6.11.10.11.5.5. Vision Coverage;
- 6.11.10.11.6. Begin date of insurance; and
- 6.11.10.11.7. End date of insurance (when terminated).
- 6.11.10.12** The MCO shall submit any new, changed, or terminated private insurance data to DHHS through file transfer on a weekly basis.
- 6.11.10.13** The MCO shall not cost avoid claims for preventive pediatric services (including EPSDT), that is covered under the Medicaid State Plan per 42 CFR 433.139(b)(3).
- 6.11.10.14** The MCO shall pay all preventive pediatric services and collect reimbursement from private insurance after the claim adjudicates.
- 6.11.10.15** The MCO shall pay the Provider for the Member's private insurance cost sharing (Copays and deductibles) up to the MCO Provider contract allowable.
- 6.11.10.16** On a quarterly basis, the MCO shall submit a cost avoidance summary, as described in Exhibit O.
- 6.11.10.17** This report shall reflect the number of claims and dollar amount avoided by private insurance and Medicare for all types of coverage as follows:
 - 6.11.10.17.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);
 - 6.11.10.17.2. Hospital coverage;

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- 6.11.10.17.3 Pharmacy coverage;
- 6.11.10.17.4 Dental coverage; and
- 6.11.10.17.5 Vision coverage.

6.11.11 Post Payment Recovery

6.11.11.1 Definitions

6.11.11.1.1 Pay and Chase means recovery of claims paid in which Medicare or private insurance was not known at the time the claim was adjudicated.

6.11.11.1.2 Subrogation means personal injury, liability insurance, automobile/home insurance, or accident indemnity insurance where a third party may be liable.

6.11.11.2 Pay and Chase Private Insurance

6.11.11.2.1 If private insurance exists for services provided and paid by the MCO, but was not known by the MCO at time the claim was adjudicated, then the MCO shall pursue recovery of funds expended from the private insurance company.

6.11.11.2.2 The MCO shall submit quarterly recovery reports, in accordance with Exhibit O.

6.11.11.2.3 These reports shall reflect detail and summary information of the MCO's collection efforts and recovery from Medicare and private insurance for all types of coverage as follows:

6.11.11.2.3.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or another other health coverage not listed below);

6.11.11.2.3.2. Hospital coverage;

6.11.11.2.3.3. Pharmacy coverage;

6.11.11.2.3.4. Dental coverage; and

6.11.11.2.3.5. Vision Coverage.

6.11.11.2.4 [Amendment #5:] The MCO shall have eight (8) months from the original paid date to initiate recovery of recover funds from private insurance.

6.11.11.2.4.1. [Amendment #5:] ~~If funds have not been recovered by that date, the claim is not on the Exhibit O TPLCOB.02 or TPLCOB.03 report for recovery within 8 months of the paid date,~~ DHHS has the sole and

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exclusive right to pursue, collect, and retain funds from private insurance.

6.11.11.2.4.2. [Amendment #5:] If a recovery is closed on the Exhibit O TPLCOB.02 or TPLCOB.03 report for any reason, DHHS has the right to initiate collections from private insurance, after the MCO closure, and retain any funds recovered.

6.11.11.2.5 The MCO shall treat funds recovered from private insurance as offsets to the claims payments by posting within the claim system.

6.11.11.2.5.1. The MCO shall post all payments to claim level detail by Member.

6.11.11.2.5.2. Any Overpayment by private insurance can be applied to other claims not paid or covered by private insurance for the same Member.

6.11.11.2.5.3. Amounts beyond a Member's outstanding claims shall be returned to the Member.

6.11.11.2.6 The MCO and its Subcontractors shall not deny or delay approval of otherwise covered treatment or services based on TPL considerations, nor bill or pursue collection from a Member for services.

6.11.11.2.7 The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of TPL is established at the time the claim is adjudicated. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.11.3 Subrogation Recoveries

6.11.11.3.1 The MCO shall be responsible for pursuing recoveries of claims paid when there is an accident or trauma in which there is a third party liable, such as automobile insurance, malpractice, lawsuit, including class action lawsuits.

6.11.11.3.2 The MCO shall act upon any information from insurance carriers or attorneys regarding potential subrogation cases. The MCO shall be required to seek Subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines.

6.11.11.3.3 The MCO shall establish detailed policies and procedures for determining, processing, and recovering funds based on accident and trauma Subrogation cases.

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6.11.11.3.4 The MCO shall submit its policies and procedures, including those related to their case tracking system as described in Section 6.11.11.3.6, to DHHS for approval during the readiness review process. The MCO shall have in its policies and procedures, at a minimum, the following:

6.11.11.3.4.1. The MCO shall establish a paid claims review process based on diagnosis and trauma codes to identify claims that may constitute an accident or trauma in which there may be a liable third party.

6.11.11.3.4.2. The claims required to be identified, at a minimum, should include ICD-10 diagnosis codes related to accident or injury and claims with an accident trauma indicator of "Y".

6.11.11.3.4.3. The MCO shall present a list of ICD-10 diagnostic codes to DHHS for approval in identifying claims for review.

6.11.11.3.4.4. DHHS reserves the right to require specific codes be reviewed by MCO.

6.11.11.3.4.5. The MCO shall establish a monthly process to request additional information from Members to determine if there is a liable third party for any accident or trauma related claims by establishing a questionnaire to be sent to Members.

6.11.11.3.4.6. The MCO shall submit a report of questionnaires generated and sent as described in Exhibit O.

6.11.11.3.4.7. The MCO shall establish timeframes and claim logic for determining when additional letters to Members should be sent relating to specific accident diagnosis codes and indicators.

6.11.11.3.4.8. The MCO shall respond to accident referrals and lien request within twenty-one (21) calendar days of the notice per RSA 167:14-a.

6.11.11.3.5 The MCO shall establish a case tracking system to monitor and manage Subrogation cases.

6.11.11.3.6 This system shall allow for reporting of case status at the request of DHHS, OIG, CMS, and any of their designees. The tracking system shall, at a minimum, maintain the following record:

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- 6.11.11.3.6.1. Date inquiry letter sent to Member, if applicable;
- 6.11.11.3.6.2. Date inquiry letter received back from Member, if applicable;
- 6.11.11.3.6.3. Date of contact with insurance company, attorney, or Member informing the MCO of an accident;
- 6.11.11.3.6.4. Date case is established;
- 6.11.11.3.6.5. Date of incident;
- 6.11.11.3.6.6. Reason for incident;
- 6.11.11.3.6.7. Claims associated with incident;
- 6.11.11.3.6.8. All correspondence and dates;
- 6.11.11.3.6.9. Case comments by date;
- 6.11.11.3.6.10. Lien amount and date updated;
- 6.11.11.3.6.11. Settlement amount;
- 6.11.11.3.6.12. Date settlement funds received; and
- 6.11.11.3.6.13. Date case closed.

6.11.11.3.7 The MCO shall submit Subrogation reports in accordance with Exhibit O. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.11.3.8 DHHS shall inform the MCO of any claims related to an MCO Subrogation cases.

6.11.11.3.9 The MCO shall submit to DHHS any and all information regarding the case if DHHS also has a Subrogation lien.

6.11.11.3.10 [Amendment #5:] The MCO shall coordinate with DHHS on any dual Subrogation settlement recoveries identified in writing by DHHS. DHHS claims shall be paid first in any dual Subrogation settlement.

6.11.11.3.10.1. [Amendment #5:] The MCO shall pay DHHS claims first in the event of any settlement less than the combined total MCO and DHHS lien amount.

6.11.11.3.10.2. [Amendment #5:] The MCO shall be liable for repayment to DHHS for the total DHHS lien amount in situations when DHHS informed the MCO of the State's lien in advance of the settlement, regardless of whether the DHHS lien amount exceeds the total

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settlement amount recovered when the MCO settles a subrogation case and accepts a settlement amount without written authorization from DHHS.

6.11.11.3.11 The MCO shall submit to DHHS for approval any Subrogation proposed settlement agreement that is less than eighty percent (80%) of the total lien in which the MCO intends to accept prior to acceptance of the settlement.

6.11.11.3.12 DHHS shall have twenty (20) business days to review the case once the MCO provides all relevant information as determined by DHHS to approve the settlement from date received from the MCO.

6.11.11.3.13 If DHHS does not respond within twenty (20) business days, the MCO may proceed with settlement.

6.11.11.3.14 If DHHS does not approve of the settlement agreement, then DHHS may work with the MCO and other parties on the settlement.

6.11.11.3.15 DHHS shall have exclusive rights to pursue subrogations in which the MCO does not have an active subrogation case within one hundred and eighty (180) calendar days of receiving a referral, of sending the first questionnaire as referenced in 6.11.11.3.4.5 of this Section, or of claim paid date if no action was taken since claims paid date.

6.11.11.3.16 In the event that there are outstanding Subrogation settlements at the time of Agreement termination, the MCO shall assign DHHS all rights to such cases to complete and collect on those Subrogation settlements.

6.11.11.3.17 DHHS shall retain all recoveries after Agreement termination.

6.11.11.3.18 The MCO shall treat funds recovered due to Subrogation, if not processed as part of claims, outside of the claims processing system as offsets to medical expenses for the purpose of reporting.

6.11.11.4 Medicare

6.11.11.4.1 The MCO shall be responsible for coordinating benefits for dually eligible Members, if applicable.

6.11.11.4.2 The MCO shall enter into a Coordination of Benefits Agreement (COBA) for NH with Medicare and participate in the automated crossover process. [42 CFR 438.3(t)]

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6.11.11.4.3 A newly contracted MCO shall have ninety (90) calendar days from the start of this Agreement to establish and start file transfers with COBA.

6.11.11.4.4 The MCO and its Subcontractors shall establish claims edits to ensure that:

6.11.11.4.4.1. Claims covered by Medicare part D are denied when a Member has an active Medicare part A or Medicare part B;

6.11.11.4.4.2. Claims covered by Medicare part B are denied when a Member has an active Medicare part B; and

6.11.11.4.4.3. The MCO treats Members with Medicare part C as if they had Medicare part A and Medicare part B and shall establish claims edits and deny part D for those part C Members.

6.11.11.4.5 If Medicare was not known or active at the time a claim was adjudicated but was determined active or retroactive at a later date, the MCO shall recoup funds from the Provider and require the Provider to pursue Medicare payment for all claim types except Medicare part D.

6.11.11.4.5.1. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.11.11.4.6 If Medicare was not known or active at the time a claim was submitted by a Provider to the MCO, but was determined active or retroactive subsequent to the MCO's payment of the claim, the MCO shall recoup funds from the Provider and the Provider may pursue Medicare payment, except for Medicare Part D, for all claim types, provided the claims remain within the timely filing requirements.

6.11.11.4.6.1. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.11.11.4.7 The MCO shall contact DHHS if Members' claims were denied due to the lack of active Medicare part D or Medicare part B.

6.11.11.4.8 The MCO shall pay applicable Medicare coinsurance and deductible amounts as outlined in Section 6.4 (Financial Responsibility for Dual-Eligible Members). These payments are included in the calculated Capitation Payment.

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6.11.11.4.9 The MCO shall pay any wrap around services not covered by Medicare that are services under the Medicaid State Plan Amendment and this Agreement.

6.11.11.5 Estate Recoveries

6.11.11.5.1 DHHS shall be solely responsible for estate recovery activities and shall retain all funds recovered through these activities.

6.12 [Amendment #3:] Risk Corridors

6.12.1 [Amendment #3:] Subject to CMS approval, DHHS shall implement a risk corridor as described in Table 1, for the September 2019 to June 2020 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

[Amendment #3:]
 Table 1
 New Hampshire Department of Health and Human Services
 Medicaid Care Management Program
[Amendment #4:] Proposed September 2019 to June 2020
 MCM Program Risk Corridor Parameters

<u>MLR Claims Corridor</u>	<u>MCO Share of Gain / Loss in Corridor</u>	<u>DHHS Share of Gain / Loss in Corridor</u>
<u>Less than Target MLR - 3.5%</u>	<u>0%</u>	<u>100%</u>
<u>Target MLR - 3.5% to Target MLR - 2.0%</u>	<u>75%</u>	<u>25%</u>
<u>Target MLR - 2.0% to Target MLR + 1.5%</u>	<u>100%</u>	<u>0%</u>
<u>Target MLR + 1.5% to Target MLR + 3.5%</u>	<u>75%</u>	<u>25%</u>
<u>Greater than Target MLR + 3.5%</u>	<u>0%</u>	<u>100%</u>

6.12.1.1 [Amendment #3:] The MCO capitation rates reflect a target medical loss ratio (MLR) which measures the projected medical service costs as a percentage of the total MCO capitation rates. The risk corridor would limit MCO gains and losses if the actual MLR is different than the target MLR.

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6.12.1.2 [Amendment #3:] The MCM program target MLR for at-risk services is 89.6% for Standard Medicaid and 88.7% for GAHCP based on the September 2019 to June 2020 projected enrollment distribution. Target MLRs will be calculated separately for each MCO based on their actual enrollment mix by rate cell.

6.12.1.3 [Amendment #3:] Table 1 summarizes the share of gains and losses relative to the target MLR for each party.

6.12.1.4 [Amendment #3:] The settlement will be done separately for the Standard Medicaid and GAHCP populations.

6.12.1.5 [Amendment #3:] Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment).

6.12.1.6 [Amendment #3:] The numerator of each MCO's actual MLR will include all payments made to providers, such as fee-for-service payments, subcapitation payments, incentive payments, and settlement payments.

6.12.1.7 [Amendment #3:] Payments and revenue related to directed payments and premium taxes will be excluded from the numerator and denominator of each MCO's actual MLR, which is consistent with the treatment of directed payments and premium taxes in federal MLR calculations.

6.12.1.8 [Amendment #3:] The 85% minimum MLR provision in the MCM contract will apply after the risk corridor settlement calculation. The 85% minimum MLR provision is adjudicated using federal MLR reporting rules, which produce a different MLR than the MLR calculated for risk corridor settlement purposes.

6.12.1.9 [Amendment #3:] The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

6.12.2 [Amendment #4:] Subject to CMS approval, DHHS shall implement a risk corridor as described in Table 1, for the July 2020 to June 2021 (SFY 2021) contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

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Table 1 New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2021 MCM Program Risk Corridor Parameters		
MLR Claims Corridor	MCO Share of Gain / Loss in Corridor	PHHS Share of Gain / Loss in Corridor
Less than Target MLR - 3.5%	0%	100%
Target MLR - 3.5% to Target MLR - 1.5%	50%	50%
Target MLR - 1.5% to Target MLR + 1.5%	100%	0%
Target MLR + 1.5% to Target MLR + 3.5%	50%	50%
Greater than Target MLR + 3.5%	0%	100%

6.12.2.1 [Amendment #4:] The MCO capitation rates reflect a target medical loss ratio (MLR) which measures the projected medical service costs as a percentage of the total MCO capitation rates. The risk corridor would limit MCO gains and losses if the actual MLR is different than the target MLR.

6.12.2.2 [Amendment #4:] The MCM program target MLR for at-risk services is 89.5% for Standard Medicaid and 88.6% for GAHCP based on the July 2020 to June 2021 projected enrollment distribution. Target MLRs will be calculated separately for each MCO based on their actual enrollment mix by rate cell.

6.12.2.3 [Amendment #4:] Table 1 summarizes the share of gains and losses relative to the target MLR for each party.

6.12.2.4 [Amendment #4:] The settlement will be done separately for the Standard Medicaid and GAHCP populations.

6.12.2.5 [Amendment #5:] Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment). [Amendment #4:] ~~Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment).~~

6.12.2.6 [Amendment #4:] The numerator of each MCO's actual MLR will include all payments made to providers, such as fee-for-service payments, subcapitation payments, incentive payments, and settlement payments.

6.12.2.7 [Amendment #4:] Payments and revenue related to directed payments and premium taxes will be excluded from the numerator and denominator of each MCO's actual MLR, which is

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consistent with the treatment of directed payments and premium taxes in federal MLR calculations.

6.12.2.8 [Amendment #4:] The 85% minimum MLR provision in the MCM contract will apply after the risk corridor settlement calculation. The 85% minimum MLR provision is adjudicated using federal MLR reporting rules, which produce a different MLR than the MLR calculated for risk corridor settlement purposes.

6.12.2.9 [Amendment #4:] The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

6.12.3 [Amendment #4:] The Granite Advantage Health Care Plan (GAHCP) risk corridor calculation shall be applied after the risk adjustment calculation.

6.12.3.1 [Amendment #4:] The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

7 TERMINATION OF AGREEMENT

7.1 Termination for Cause

7.1.1 DHHS shall have the right to terminate this Agreement, in whole or in part, without liability to the State, if the MCO:

7.1.1.1 Takes any action or fails to prevent an action that threatens the health, safety or welfare of any Member, including significant Marketing abuses;

7.1.1.2 Takes any action that threatens the fiscal integrity of the Medicaid program;

7.1.1.3 Has its certification suspended or revoked by any federal agency and/or is federally debarred or excluded from federal procurement and/or non-procurement agreement;

7.1.1.4 Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

7.1.1.5 Violates State or federal law or regulation;

7.1.1.6 Fails to carry out a substantive term or terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

7.1.1.7 Becomes insolvent;

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7.1.1.8 Fails to meet applicable requirements in Sections 1932, 1903 (m) and 1905(t) of the Social Security Act.; [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]

7.1.1.9 Receives a "going concern" finding in an annual financial report or indications that creditors are unwilling or unable to continue to provide goods, services or financing or any other indication of insolvency; or

7.1.1.10 Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily under Title 11 of the U.S. Code.

7.2 Termination for Other Reasons

7.2.1 The MCO shall have the right to terminate this Agreement if DHHS fails to make agreed-upon payments in a timely manner or fails to comply with any material term or condition of this Agreement, provided that, DHHS has not cured such deficiency within sixty (60) business days of its receipt of written notice of such deficiency.

7.2.2 This Agreement may be terminated for convenience by either the MCO or DHHS as of the last day of any month upon no less than one-hundred twenty (120) business days prior written notice to the other party.

7.2.3 Notwithstanding Section 7.2.2, this Agreement may be terminated immediately by DHHS if federal financial participation in the costs hereof becomes unavailable or if State funds sufficient to fulfill its obligations of DHHS hereunder are not appropriated by the Legislature. In either event, DHHS shall give MCO prompt written notice of such termination.

7.2.4 Notwithstanding the above, the MCO shall not be relieved of liability to DHHS or damages sustained by virtue of any breach of this Agreement by the MCO.

7.2.5 Upon termination, all documents, data, and reports prepared by the MCO under this Agreement shall become the property of and be delivered to DHHS immediately on demand.

7.2.6 DHHS may terminate this Agreement, in whole or in part, and place Members into a different MCO or provide Medicaid benefits through other Medicaid State Plan Authority, if DHHS determines that the MCO has failed to carry out the substantive terms of this Agreement or meet the applicable requirements of Sections 1932, 1903(m) or 1905(t) of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act].

7.2.6.1 In such event, Section 4.7.9 (Access to Providers During Transition of Care) shall apply.

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7.3 Claims Responsibilities

7.3.1 The MCO shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

7.3.2 The MCO shall be financially responsible for all other authorized services when the service is provided on or before the last day of the Closeout Period (defined in Section 7.7.3 (Service Authorization/Continuity of Care) below, or if the service is provided through the date of discharge.

7.4 Final Obligations

7.4.1 DHHS may withhold payments to the MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Such withheld payments may be used as a set-off and/or applied to the MCO's outstanding final financial obligations.

7.4.2 If all financial obligations of the MCO have been satisfied, amounts due to the MCO for unpaid premiums, risk settlement, High Dollar Stop Loss, shall be paid to the MCO within one (1) year of date of termination of the Agreement.

7.5 Survival of Terms

7.5.1 Termination or expiration of this Agreement for any reason shall not release either the MCO or DHHS from any liabilities or obligations set forth in this Agreement that:

7.5.1.1 The parties have expressly agreed shall survive any such termination or expiration; or

7.5.1.2 Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any such termination or expiration, or obliges either party by law or regulation.

7.6 Agreement Closeout

7.6.1 Period

7.6.1.1 DHHS shall have the right to define the close out period in each event of termination, and such period shall take into consideration factors such as the reason for the termination and the timeframe necessary to transfer Members.

7.6.1.2 During the closeout period, the MCO shall work cooperatively with, and supply program information to, any subsequent MCO and DHHS.

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7.6.1.3 Both the program information and the working relationships between the two MCOs shall be defined by DHHS.

7.6.2 Data

7.6.2.1 The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including but not limited to Encounter Data, to the new MCO and/or DHHS during the closeout period to ensure a smooth transition of responsibility.

7.6.2.2 The new MCO and/or DHHS shall define the information required from the MCO during this period and the time frames for submission.

7.6.2.3 All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied.

7.6.2.4 The MCO shall transmit the information and records required under this Section within the time frames required by DHHS.

7.6.2.5 DHHS shall have the right, in its sole discretion, to require updates to these data at regular intervals.

7.6.2.6 The MCO shall be responsible for continued submission of data to the CHIS during and after the transition in accordance with NHID regulations.

7.6.3 Service Authorization/Continuity of Care

7.6.3.1 Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with DHHS and/or its designee to process service authorization requests received.

7.6.3.1.1 Disputes between the MCO and DHHS and/or its designee regarding service authorizations shall be resolved by DHHS in its sole discretion.

7.6.3.2 The MCO shall give written notice to DHHS of all service authorizations that are not decided upon by the MCO within fourteen (14) calendar days prior to the last day of the closeout period.

7.6.3.2.1 Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

7.6.3.3 The Member has access to services consistent with the access they previously had, and is permitted to retain their current Provider for the period referenced in Section 4.7.9 (Access to

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Providers During Transitions of Care) for the transition timeframes if that Provider is not in the new MCO's network of Participating Providers.

7.6.3.4 The Member shall be referred to appropriate Participating Providers.

7.6.3.5 The MCO that was previously serving the Member, fully and timely complies with requests for historical utilization data from the new MCO in compliance with State and federal law.

7.6.3.6 Consistent with State and federal law, the Member's new Provider(s) are able to obtain copies of the Member's medical records, as appropriate.

7.6.3.7 Any other necessary procedures as specified by the HHS Secretary to ensure continued access to services to prevent serious detriment to the Member's health or reduce the risk of hospitalization or institutionalization.

7.6.3.8 DHHS shall make any other transition of care requirements publically available.



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Exhibit B Method and Conditions Precedent to Payment - Amendment #10

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit A. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

July 1, 2023 – August 31, 2024

Medicaid Care Management

Base Population

	Capitation Rate
Foster Care / Adoption Subsidy	\$428.42
Severely Disabled Children (DD & IHS)	1,682.15
Low Income Children - Age 0 - 11 months	404.28
Low Income Children - Age 1 - 18	197.72
Low Income Adults - Age 19+	487.49
Elderly and Disabled Adults - Age 19 - 64	1,433.61
Dual Eligibles (all dual rate cells)	278.83
Elderly and Disabled Adults - Age 65+	1,174.03
CHIP	186.44

Behavioral Health Population Rate Cells

Severe & Persistent Mental Illness: Dual	\$ 1,723.35
Severe & Persistent Mental Illness: Non Dual	2,374.70
Severe Mental Illness: Dual	1,137.10
Severe Mental Illness: Non Dual	1,666.72
Low Utilizer - Dual	684.24
Low Utilizer - Non Dual	1,650.59
SED Child - TANF and Foster Care	1,117.54

Medicaid Expansion

Medically Frail	\$1,106.91
Non-Medically Frail	483.31

Maternity/Newborn Kick Payments:

Maternity kick Payment	\$ 3,385.41
Newborn kick Payment	6,762.03
Neonatal Abstinence Syndrome kick Payment	21,023.17



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Exhibit B Method and Conditions Precedent to Payment - Amendment #10

For each of the subsequent years of the Agreement, actuarially sound per Member, per month capitated rates shall be paid as calculated and certified by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

Any rate adjustments shall be subject to the availability of State appropriations.

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for the fourteen month contract period covering State Fiscal Year 2024, July 1, 2023 – June 30, 2024, and State Fiscal Year 2025 July 1, 2024 – August 31, 2024 to be served among all contracts is 2,499,560. Accordingly, the price limitation for the fourteen month contract period July 1, 2023 – August 31, 2024 among all contracts is \$ 1,209,229,580 based on the projected members per month. The full price limitation is \$ 5,928,058,454.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

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EXHIBIT O – Quality and Oversight Reporting Requirements Amendment #10

1. General

- 1.1. The list of deliverables in Exhibit O provides a high-level summary of what each deliverable will entail. *Please note all information is subject to revision and refinement as NH DHHS finalizes the specifications for each deliverable.*
- 1.2. The Exhibit O measures/measure sets, logs, and narrative reports shall be submitted according to the specified schedule. Submission formats shall either be the standard HEDIS submission format for HEDIS measures or as specified by NH DHHS for other measures, data tables and reports.
- 1.3. NH DHHS utilizes measures from several measure stewards, including NCQA and the Pharmacy Quality Alliance (PQA). The MCO is responsible for contracting with these entities or associated vendors as appropriate for producing deliverables.
- 1.4. To help insure the successful generation of consistent Exhibit O deliverables (both over time for each MCO and across all MCOs), the following processes will be in place.
 - 1.4.1. NH DHHS shall:
 - 1.4.1.1. Identify specifications for each deliverable;
 - 1.4.1.2. Engage the MCOs in the development of measures as appropriate;
 - 1.4.1.3. Schedule "Exhibit O" meetings (webinars, typically held on Friday afternoons) with the MCOs to:
 - 1.4.1.3.1. Review all deliverable specifications;
 - 1.4.1.3.2. Provide clarifications as needed by the MCOs;
 - 1.4.1.3.3. Establish initial due dates for all deliverables.
 - 1.4.1.4. Provide training for use of the NH Medicaid Quality Information System (MQIS) and the DHHS SharePoint site;
 - 1.4.1.5. Contact MCO compliance staff to validate suspected reporting discrepancies.
 - 1.4.2. MCO compliance staff and appropriate subject matter experts (SMEs) shall:
 - 1.4.2.1. Review, sign, and comply with all applicable DHHS and DoIT applicable policies and procedures;
 - 1.4.2.2. Review all specifications for clarity and request more information as needed;
 - 1.4.2.3. Participate in measure development activities as appropriate;
 - 1.4.2.4. Participate in the "Exhibit O" meetings;
 - 1.4.2.5. Follow the finalized specifications for submission of deliverables;
 - 1.4.2.6. Gain access to and utilize the MQIS, including participation in any DHHS required training necessary;
 - 1.4.2.7. Submit all data as required to MQIS using MQIS specified formats;
 - 1.4.2.8. Submit deliverables as required to the DHHS SharePoint site;
 - 1.4.2.9. Respond to system generated error reports;

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**EXHIBIT O – Quality and Oversight Reporting Requirements
 Amendment #10**

- 1.4.2.10. Respond to requests from DHHS staff to validate suspected reporting discrepancies.
- 1.5. The Department reserves the right to develop and require alternative methodologies to submit data.
2. Key Definitions
- 2.1. The following terms include some of the unique or new terms found in Exhibit O. Please reference Exhibit A for more details.

Term	Definition
2.1.1. Community Hospital	Any hospital other than New Hampshire Hospital
2.1.2. Community Mental Health Program or CMHP, High Risk / High Need, Local Care Management, and Priority Populations	As defined in Exhibit A.
2.1.3. Subpopulations	<p>Subpopulations consist of components used together to classify a member and are used for selected measures as indicated in the NH Medicaid Care Management Quality and Oversight Reporting Deliverables table below.</p> <p>General subpopulations utilize the following components: Age Group, Member Type, LTSS Type, and Payer Type. Measures use specific components in conjunction based on the measurement intent.</p> <p>Each component is broken down into the following categories that have standardized definitions used consistently across all measures:</p> <ul style="list-style-type: none"> • Age Group (<i>Children, Adults, Older Adults</i>), • Member Type (<i>DCYF Involved Child, Child with Severe Disabilities (HC-CSD, SSI, SMS), Other Special Needs Child, Other Child, Special Needs Adult, All Other Adults, All Older Adults</i>), • LTSS Type (<i>Receiving LTC Services (Waiver or Nursing Home), Eligible for CMHC Services and Not Also Waiver/Nursing Home, Not Receiving Waiver, CMHC, or Nursing Home</i>), and • Payer Type (<i>Medicaid Primary, Medicare Primary, Other Primary</i>)

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
ACCESSREQ.05	Requests for Assistance Accessing MCO Designated Primary Care Providers by County	Count and percent of member telephone and/or email requests for assistance accessing MCO Designated Primary Care Providers (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer appearing on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period							X	
ACCESSREQ.06	Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County	Count and percent of member telephone and/or email requests for assistance accessing non-MCO Designated Physician/APRN Specialists (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period							X	
AMBCARE.10	Physician/APRN/Clinic Visits	Count and percent of Physician/APRN/Clinic visits per 1,000 member months by subpopulation.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
AMBCARE.11	Emergency Department Visits for Physical Health Conditions	Count and percent of Ambulatory emergency department (ED) visits per 1,000 member months by subpopulation. This measure excludes ED visits for mental health and substance use disorder/substance misuse conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.12	Emergency Department Visits - Potentially Treatable in Primary Care	Count and percent of Ambulatory emergency department visits for conditions potentially treatable in primary care per 1,000 member months by subpopulation.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.13	Emergency Department Visits - Mental Health Conditions	Count and percent of Ambulatory emergency department (ED) visits for mental health conditions per 1,000 member months by subpopulation. This measure excludes ED visits for substance use disorder/substance misuse conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X	X	
AMBCARE.14	Emergency Department Visits - Substance Use Disorder and Substance Misuse Related Conditions	Count and percent of Ambulatory emergency department visits for substance use disorder (SUD) and substance misuse related conditions per 1,000 member months by subpopulation. This measure excludes ED visits for mental health conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.18	Frequent Emergency Department Use	Count and percent of members with frequent ED use in the previous 12 months, by subpopulation. Frequent ED use is defined as 4+ visits in a 12-month period. This measure includes ED visits for physical health, mental health and substance use disorder/substance misuse conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.20	Emergency Department Visits for Any Condition by Subpopulation	Count and percent of all Ambulatory emergency department (ED) visits for Medical Health, Behavioral Health and Substance Use Related (Chronic or Acute) Conditions (Total counts, not broken out by condition group).	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X	X	

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
ANNUALRPT.01	Medicaid Care Management Program Comprehensive Annual Report	The annual report is the Managed Care Organization's PowerPoint presentation on the accomplishments and opportunities of the prior agreement year. The report will address how the MCO has impacted Department priority issues, social determinants of health, improvements to population health, and developed innovative programs. The audience will be the NH Governor, legislature, and other stakeholders.	Narrative Report		Agreement Year	Annually	August 30th						X		X
APM.01	Alternative Payment Model Plan	Implementation plan that meets the requirements for Alternative Payment Models outlined in the MCM Model Contract and the Department's Alternative Payment Model Strategy.	Plan		Varies	Annually	May 1st								X
APM.02	Alternative Payment Model Quarterly Update	Standard template showing the quarterly results of the alternative payment models.	Table		Varies	Quarterly	4 Months after end of Measurement Period								X
APM.03	Alternative Payment Model Completed HCP-LAN Assessment Results	The HCP-LAN Assessment is available at: https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf ; the MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).	Narrative Report		Varies	Annually	October 31st								X
APPEALS.01	Resolution of Standard Appeals Within 30 Calendar Days	Count and percent of appeal resolutions of standard appeals within 30 calendar days of receipt of appeal for appeals filed with the MCO during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.02	Resolution of Extended Standard Appeals Within 44 Calendar Days	Count and percent of appeal resolutions of extended standard appeals within 44 calendar days of receipt of appeal for appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
APPEALS.03	Resolution of Expedited Appeals Within 72 Hours	Count and percent of appeal resolutions of expedited appeals within 72 hours of receipt of appeal for appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.04	Resolution of All Appeals Within 45 Calendar Days	Count and percent of appeal resolutions within 45 calendar days of receipt of appeal for appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.05	Resolution of Appeals by Disposition Type	Count and percent of appeals where member abandoned appeal, MCO action was upheld, or MCO action was reversed for all appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.16	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Standard template that provides counts of MCO resolved appeals by resolution type (i.e. upheld, withdrawn, abandoned) by category of service. The counts are broken out by State Plan and 1915B waiver populations.	Table		Quarter	Quarterly	2 Months after end of Measurement Period				X	X	X		
APPEALS.17	Pharmacy Appeals by Type of Resolution and Therapeutic Drug Class by State Plan, 1915B Waiver, and Total Population	Standard template providing counts of MCO appeals resolutions by resolution type and category of pharmacy class	Table		Quarter	Quarterly	2 Months after end of Measurement Period				X	X	X		
APPEALS.18	Services Authorized within 72 Hours Fol03 - Lowing a Reversed Appeal	Count and percent of services authorized within 72 hours fol03 - Lowing a reversed appeal for the service that was previously denied, limited or delayed by the MCO.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.19	Member Appeals Received	Count and percent of Member appeals filed during the measurement data period, per 1,000 member months.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
BHDRUG.01	Severe Mental Illness Drug Prior Authorization Report	Standard template to monitor MCO pharmacy service authorizations (SA) for drugs to treat severe mental illness that are prescribed to members receiving services from Community Mental Health Programs. The report includes aggregate data detail related to SA processing timeframes, untimely processing rates, peer-to-peer activities, SA approval and denial rates. The report also includes a log of member specific information related to SA denials.	Table		Quarter	Quarterly	1 Month after end of Measurement Period								X
BHPARITY.01	Behavioral Health Parity Attestation	Standard report for MCO to attest to compliance with behavioral health parity requirements.	Table		Calendar Year	Annually	January 31st						X		X
BHSTRATEGY.01	Behavioral Health Strategy Plan and Report	Annual comprehensive plan describing the MCOs policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers.	Plan		Agreement Year	Annually	<u>May 15th</u>							X	X
BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report	Standard template to report the results of the annual behavioral health consumer satisfaction survey for members with mental health and substance use disorder (SUD) conditions. The report includes all mandatory questions for the survey.	Table		Calendar Year	Annually	June 30th	X							

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Description			Measurement Period and Delivery Dates				Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAHPS_A.01	Adult CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the Adult Medicaid CAHPS 5.0 survey population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3; Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X		X			X		
CAHPS_A.02	Adult CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the Adult Medicaid CAHPS 5.0H Validated Member Level Data File.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X		X			X		
CAHPS_A.03	Adult CAHPS: Medicaid Adult Survey Results Report	This report includes summary information about the Adult Medicaid CAHPS 5.0H survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X		X			X		
CAHPS_A.04	Adult CAHPS: CAHPS Survey Results with Confidence Intervals	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X		X			X		
CAHPS_A.05	Adult CAHPS: Survey Instrument Proofs created by Survey Vendor	Adult Medicaid CAHPS 5.0H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	Feb 28th	X		X			X		

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Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAHPS_A_SUP	Adult CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure		Standard HEDIS Schedule	Annually	July 31st	X					X		X
CAHPS_CCC.01	Child w CCC CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the CAHPS Medicaid Child with CCC 5.0H survey population. This file will include respondents identified as either General Population, or Child with Chronic Conditions (Child with CCC) Population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3, Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/ CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
CAHPS_CCC.02	Child w CCC CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the CAHPS Child with CCC 5.0H Survey Validated Member Level Data File.	HEDIS/ CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
CAHPS_CCC.03	Child w CCC CAHPS: Medicaid Child with CCC - CCC Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		

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Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	EMHA	DHHS Monitoring
CAHPS_CCC.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - Child with CCC	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X	X					X	
CAHPS_CCC.05	Child w CCC CAHPS: Survey Instrument Proofs created by Survey Vendor	CAHPS Child with CCC 5.0H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	Feb 28th	X	X					X	
CAHPS_CCC_SUP	Child CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCOA, typically questions developed by AHRQ.	Measure		Standard HEDIS Schedule	Annually	July 31st	X						X	X
CAHPS_CGP.03	Child w CCC CAHPS: Medicaid Child with CCC - General Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X					X	
CAHPS_CGP.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - General Population	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X	X					X	

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CARECOORD.03	Neonatal Abstinence Syndrome Referrals to Care Management	Count and percent of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) during the measurement quarter referred to case management within 30 calendar days of diagnosis.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
CARECOORD.04	Neonatal Abstinence Syndrome Engagement in Care Management	Count and percent of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) during the measurement quarter who enrolled with the MCO care management program within 30 days of the referral.	Measure		Quarter	Quarterly	5 Months after end of Measurement Period								X
CAREMGT.01	Care Management Plan Including Plan to Assess and Report on the Quality and Appropriateness of Care Furnished to Members With Special Health Care Needs	Overview of the MCO plan to implement and operate their comprehensive care management program for the next agreement year.	Plan		Agreement Year	Annually	May 1st								X
CAREMGT.23	Care Management Comprehensive Assessments Completed by Subcontractor Entity	Percent of completed comprehensive assessments in the quarter completed by a subcontractor entity.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.24	Care Management: Comprehensive Assessment Attempts Completed Within 30 Days	Count and percent of members requiring a comprehensive assessment within 30 days of being identified as requiring this assessment, by outcome of MCO completion attempts.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAREMGT.25	Care Management Comprehensive Assessment Results within 14 Calendar Days	Percent of members with a comprehensive assessment completed during the measurement quarter, where the assessment results were shared in writing with members of the local-based care team within 14 calendar days of being established. The local-based care team includes but is not limited to the member's PCP, specialist, behavioral health provider, and local care management entity.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.26	Care Management Resources - Unmet Needs	Standard template aggregating by county, resource needs (e.g. housing supports, providers) that cannot be met because they are not locally available. Data will be based on the care screening and comprehensive assessments conducted during the quarter.	Table		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.28	Care Management: Members Receiving Care Management by Priority Population	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by priority populations outlined in the Care Coordination and Care Management section of the MCM Contract. Enrollment in care management is defined as the member having a completed plan of care.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X
CAREMGT.29	Care Management Outreach to High-Risk/High-Need Members	Count and percent of members who received outreach from the MCO to enroll in care management within 30 calendar days of being identified as High-risk or High-need through a completed comprehensive assessment, by the outcome of MCO outreach.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.32	Members Receiving Face-to-Face Local Care Management	Count and percent of members enrolled in local care management during the measurement quarter, who had at least one face-to-face meeting with their local case manager or designee during the quarter.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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CAREMGT.39	Members Enrolled in Care Management	Count and percent of members enrolled in care management on the last day of the month. Enrollment in care management is defined as the member having a completed plan of care.	Measure		Month	Monthly	1 Month after end of Measurement Period					X			X
CAREMGT.40	Members Enrolled in Care Management at Any Time During the Month	Count and percent of members enrolled in care management at any time during the month. Enrollment in care management is defined as the member having a completed plan of care.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.41	Members Receiving Local Care Management by Geographic Region	Count and percent of members who are enrolled in care management and receiving local care management at the end of the measurement month, by geographic region.	Measure		Month	Monthly	1 Month after end of Measurement Period								X
CAREMGT.42	Members Identified as High-Risk/High-Need Receiving Care Management	Count and percent of members identified as "High-risk"/"High-need" through the comprehensive assessment completed in the measurement quarter, who enrolled in care management within 30 calendar days of completion of the comprehensive assessment.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.43	Members Receiving Care Management by Geographic Region	Count and percent of members who are enrolled in care management at the end of the measurement month, by geographic region.	Measure		Month	Monthly	1 Month after end of Measurement Period								X

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CAREMGT.44	Successful Member Welcome Calls	<p>Count and percent of members newly enrolled in an MCO during the measurement period for whom the MCO completed a welcome call within 30 calendar days of enrollment. The welcome call contract requirements are as follows:</p> <ul style="list-style-type: none"> • The MCO shall make a welcome call to each New Member within thirty (30) calendar days of the Member’s enrollment in the MCO. • The welcome call shall, at a minimum: <ul style="list-style-type: none"> o Assist the Member in selecting a PCP or confirm selection of a PCP; o Arrange for a wellness visit with the Member’s PCP (either previously identified or selected by the Member from a list of available PCPs), which shall include: <ul style="list-style-type: none"> o Assessments of both physical and behavioral health, o Screening for depression, mood, suicidality, and Substance Use Disorder, and o Development of a health, wellness and care plan; o Include a Health Risk Assessment Screening as required in Section 4.10.2.2, or schedule the Health Risk Assessment to be conducted within the time limits identified in this Agreement; o Screen for special needs, physical and behavioral health, and services of the Member; o Answer any other Member questions about the MCO; o Ensure Members can access information in their preferred language; and o Remind Members to report to DHHS any change of address, as Members shall be liable for premium payments paid during period of ineligibility. 	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X
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CAREMGT.45	New Member Welcome Calls – MCO Arranged Wellness Visit	Count and percent of members newly enrolled in an MCO during the measurement period for whom the MCO completed a welcome call within 30 calendar days of enrollment and arranged a wellness visit for the member or other covered family member, broken out by the results of the wellness visit conversation. • MCO Arranged Wellness Visit • Member Declined MCO Assistance to Arrange Wellness Visit • Member Wanted Assistance to Arrange Wellness Visit but MCO was Unable to Arrange Visit • MCO Did Not Offer to Arrange Wellness Visit	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X
CAREMGT.46	New Member Wellness Visits – Visit Occurred	Count and percent of members newly enrolled in an MCO during the measurement period where the member had a wellness visit within 6 months of their enrollment date.	Measure		Quarter	Quarterly	10 Months after end of Measurement Period								X
CLAIM.08	Interest on Late Paid Claims	Total interest paid on professional and facility claims not paid within 30 calendar days of receipt using interest rate published in the Federal Register in January of each year for the Medicare program. Note: Claims include both Medical and Behavioral Health claims.	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period						X		X
CLAIM.11	Professional and Facility Medical Claim Processing Results	Count and percentage of professional and facility medical claims received in the measurement period, with processing status on the last day of the measurement period that are Paid, Suspended, or Denied.	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period						X		X

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CLAIM.17	Average Pharmacy Claim Processing Time	The average pharmacy claim processing time per point of service transaction, in seconds. The contract standard in Amendment 7, section 14.1.9 is: The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds. Note: Claims include both Medical and Behavioral Health claims.	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period						X		X
CLAIM.21	Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt	Count and percent of clean electronic provider claims processed within 15 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period					X	X		X
CLAIM.22	Timely Processing of Non-Electronic Provider Claims: Thirty Days of Receipt	Count and percent of clean non-electronic provider claims processed within 30 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period					X	X		X
CLAIM.23	Timely Processing of All Clean Provider Claims: Thirty Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period					X	X		X

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CLAIM.24	Timely Processing of All Clean Provider Claims: Ninety Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 90 calendar days of receipt of the claim, for those received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT) claims.	Measure		Month	Monthly	110 Calendar Days after end of Measurement Period						X		X
CLAIM.25	Claims Quality Assurance - Claims Payment Accuracy	Sampled percent of all provider claims that are paid or denied correctly during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure		Quarter	Quarterly	50 Calendar Days after end of Measurement Period					X	X		X
CLAIM.26	Claims Quality Assurance: Claims Financial Accuracy	Sampled percent of dollars accurately paid for provider claims during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims. Note: It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.	Measure		Quarter	Quarterly	50 Calendar Days after end of Measurement Period					X	X		X

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CLAIM.27	Claims Quality Assurance: Claims Processing Accuracy	Sampled percent of all provider claims that are accurately processed in their entirety from both a financial and non-financial perspective during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure		Quarter	Quarterly	50 Calendar Days after end of Measurement Period					X	X		X
CMS_A_AMM.01	Antidepressant Medication Management: Effective Acute Phase Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS AMM measure.	Measure		May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	September 30th			X					
CMS_A_AMM.02	Antidepressant Medication Management: Effective Continuation Phase Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS AMM measure.	Measure		May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	September 30th			X					
CMS_A_AMR	Asthma Medication Ratio	CMS Adult Core Set - Age breakout of data collected for HEDIS AMR measure.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_BCS	Breast Cancer Screening	CMS Adult Core Set - Age breakout of data collected for HEDIS BCS measure.	Measure		2 Calendar Years	Annually	September 30th			X					

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					Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring	
CMS_A_CBP	Controlling High Blood Pressure	CMS Adult Core Set - Age breakout of data collected for HEDIS CBP measure.	Measure		Calendar Year	Annually	September 30th			X						
CMS_A_CCP.01	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days	CMS Adult and Child Core Sets - The percentage of women ages 15 through 44 who had a live birth and were provided a most or moderately effective method of contraception within 3 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X						
CMS_A_CCP.02	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a most or moderately effective method of contraception within 60 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X						
CMS_A_CCP.03	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 3 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X						
CMS_A_CCP.04	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 60 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 60 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X						
CMS_A_CDF	Screening for Clinical Depression and Follow-up Plan	CMS Adult and Child Core Sets (member age determines in which set the member is reported).	Measure		Calendar Year	Annually	September 30th		X	X						
CMS_A_COL	Colorectal Cancer Screening	CMS Adult Core Set - Age breakout of data collected for HEDIS COL measure.	Measure		Calendar Year with a 10 Year Look-back	Annually	September 30th			X						
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set - Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	Measure		Calendar Year	Annually	September 30th			X	X					

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					Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CMS_A_FUA.01	Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Within 7 Days of ED Visit	CMS Adult Core Set - Age breakout of data collected for HEDIS FUA measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_FUA.02	Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Within 30 Days of ED Visit	CMS Adult Core Set - Age breakout of data collected for HEDIS FUA measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_HBD.01	Hemoglobin A1c Control for Patients With Diabetes - HbA1c control (<8.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c control (<8.0%).	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_HBD.02	Hemoglobin A1c Control for Patients With Diabetes - HbA1c poor control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c poor control (>9.0%).	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for a former HEDIS measure.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_IET.01	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.02	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				

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CMS_A_IET.03	Initiation of Alcohol Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.04	Engagement of Alcohol Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.05	Initiation of Opioid Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.06	Engagement of Opioid Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.07	Initiation of Other Drug Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.08	Engagement of Other Drug Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_INP_PQI01	Diabetes Short-Term Complication Admissions	CMS Adult Core Set - Diabetes Short-Term Complications Admission Rate per 100,000 Member Months	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_INP_PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions	CMS Adult Core Set - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_INP_PQI08	Heart Failure Admissions	CMS Adult Core Set - Heart Failure Admission Rate per 100,000 Enrollee Months	Measure		Calendar Year	Annually	September 30th			X					

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CMS_A_INP_PQJ15	Asthma in Younger Adults Admissions	CMS Adult Core Set - Asthma In Younger Adults Admission Rate per 100,000 Enrollee Months	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_MSC.01	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_MSC.02	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_MSC.03	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_OHD	Use of Opioids from Multiple Providers at High Dosage In Persons Without Cancer: Opioid High Dosage	CMS Adult Core Set - The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.01	Use of Pharmacotherapy for Opioid Use Disorder - Total	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed medication for the disorder.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.02	Use of Pharmacotherapy for Opioid Use Disorder - Buprenorphine	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Buprenorphine.	Measure		Calendar Year	Annually	September 30th			X	X				

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CMS_A_OUD.03	Use of Pharmacotherapy for Opioid Use Disorder - Oral Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Oral Naltrexone.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.04	Use of Pharmacotherapy for Opioid Use Disorder - Long-Acting, Injectable Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Long-Acting, Injectable Naltrexone.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.05	Use of Pharmacotherapy for Opioid Use Disorder - Methadone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Methadone.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_CCW.01	Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_CCW.02	Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_CH_DEV	Developmental Screening in the First Three Years of Life	CMS Child Core Set - Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Measure		Calendar Year	Annually	September 30th		X						

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CULTURALCOMP.01	Cultural Competency Strategic Plan	MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by communication access utilization reports, quality improvement data disaggregated by race, ethnicity and language, and the community assessments and profiles.	Plan		Agreement Year	Annually	May 1st								X
DUR.01	Drug Utilization Review (DUR) Annual Report	This annual report includes Center for Medicaid and Medicaid Services (CMS) required information on the operation of the MCO's Medicaid DUR Program.	Narrative Report		Federal Fiscal Year	Annually	May 15th						X		X
EMERGENCY RESPONSE.01	Emergency Response Plan	Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs, including, but not limited to, specific pandemic and natural disaster preparedness. After the initial submission of the plan the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.	Plan		Agreement Year	Annually	May 1st								X
EPSDT.01	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	Standard template that captures the total paid units of each of the ABA services by member for the purpose of fiscal impact analysis.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X

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EPSDT.20	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	MCO EPSDT plan includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure provider network compliance that all members under age 21 receive all the elements of the preventive health screenings recommended by the AAP's most currently published Bright Futures guidelines for well-child care in accordance with the EPSDT periodicity schedule. Additionally, the MCO EPSDT plan must include written policies and procedures for the provision of a full range of EPSDT diagnostic and treatment services.	Plan		Agreement Year	Annually	May 1st								X
EQRO.01	MCO Follow-up on EQRO Recommendations	This semi-annual report will provide a description of actions taken to address select MCO-specific findings/recommendations identified by NH EQRO quality reports.	Narrative Report		6 Months	Semi-Annually	1 Month after end of Measurement Period								X
FINANCIALSTMT.01	MCO Annual Financial Statements	The MCO shall provide DHHS a complete copy of its audited financial statements and amended statements.	Narrative Report		MCO Financial Period	Annually	August 10th								X
FWA.02	Fraud Waste and Abuse Log: FWA Related to Providers	Standard template log of all Fraud Waste and Abuse related to providers, in process and completed during the month by the MCO or its subcontractors. This log includes but is not limited to case information, current status, and final outcome for each case including overpayment and recovery information.	Table		Month	Monthly	1 Month after end of Measurement Period						X		X
FWA.04	Fraud Waste and Abuse Log: Date of Death Report	Standard template that captures a list of members who expired during the measurement period.	Table		Month	Monthly	1 Month after end of Measurement Period						X		X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
FWA.05	Fraud Waste and Abuse Log: Explanation Of Medical Benefit Report	Standard template that includes a summary explanation of medical benefits sent and received including the MCO's follow-up, action/outcome for all EMB responses that required further action.	Table		Quarter	Quarterly	1 Month after end of Measurement Period						X		X
FWA.06	Fraud Waste and Abuse Log: Waste Recovery Report	Standard template reporting waste identified and recovered by the MCO.	Table		Quarter	Quarterly	1 Month after end of Measurement Period								X
FWA.20	Comprehensive Annual Prevention of Fraud Waste and Abuse Summary Report	The MCO shall provide a summary report on MCO Fraud, Waste and Abuse investigations. This should include a description of the MCO's special investigation's unit. The MCO shall describe cumulative overpayments identified and recovered, investigations initiated, completed, and referred, and an analysis of the effectiveness of activities performed. The MCO's Chief Financial Officer will certify that the information in the report is accurate to the best of his or her information, knowledge, and belief.	Narrative Report		Agreement Year	Annually	September 30th						X		X
GRIEVANCE.02	Grievance Log Including State Plan / 1915B Waiver Flag	Standard template log of all grievances with detail on grievances and any corrective action or response to the grievance for grievances made within the measure data period.	Table		Quarter	Quarterly	15 Calendar Days after end of Measurement Period				X	X	X		
GRIEVANCE.03	Member Grievances Received	Count and Percent of member grievances received during the measure data period, per 1,000 member months.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		
GRIEVANCE.05	Timely Processing of All Grievances	Count and percent of grievances processed within contract timeframes for grievances made during the measurement period.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period	X					X		

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HEDIS.01	HEDIS Roadmap	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
HEDIS.02	HEDIS Data Filled Workbook	Workbook containing the NCQA audited results for all HEDIS measures, with one measure appearing on each tab.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
HEDIS.03	HEDIS Comma Separated Values Workbook	This file includes NCQA audited results for all HEDIS measures, and should include the Eligible Population and/or Denominator, Numerator, Rate, and Weight (for hybrid measures) for each measure.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
HEDIS.04	NCQA HEDIS Compliance Audit™ Final Audit Report	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X	X				X		
HEDIS.06	HEDIS Member Level Data	This file contains member/event level data for select HEDIS measures. Data will reflect the NCQA audited results for these measures in the corresponding HEDIS Data-Filled Workbook for the same measurement period. The current list of DHHS-selected HEDIS measures appears in <i>Appendix AF - HEDIS Measures Included in HEDIS.06</i> and is subject to change each measurement year.	HEDIS/CAHPS Files		Calendar Year	Annually	June 30th								

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HEDIS_AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	HEDIS Measure, also utilized for CMS Core Sets	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X	X	X					
HEDIS_ADD	Follow-Up Care for Children Prescribed ADHD Medication	HEDIS Measure, also utilized for CMS Core Sets	Measure		One year starting March 1 of year prior to measurement year to February 28 of measurement year.	Annually	June 30th	X	X						X
HEDIS_AIS-E	Adult Immunization Status - Influenza, Td/Tdap, Zoster, Pneumococcal	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_AMB	Outpatient and Emergency Dept. Visits/1000 Member Months	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th		X		X				X

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HEDIS_AMM	Antidepressant Medication Management	HEDIS Measure, also utilized for CMS Core Sets	Measure		May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	June 30th	X		X					X
HEDIS_AMR	Asthma Medication Ratio	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X	X					
HEDIS_APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_AXR	Antibiotic Utilization for Respiratory Conditions (AXR)	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_BCS	Breast Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure		2 Calendar Years	Annually	June 30th	X		X					X
HEDIS_BCS-E	Breast Cancer Screening	HEDIS Measure	Measure		2 Calendar Years	Annually	June 30th	X							X
HEDIS_BPD	Blood Pressure Control (<140/90) (BPD)	HEDIS Measure formerly part of HEDIS_CDC, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th	X							X
HEDIS_CBP	Controlling High Blood Pressure	HEDIS Measure. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th	X		X					X

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HEDIS_CCS	Cervical Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure		3 Calendar Years	Annually	June 30th	X		X					X
HEDIS_CHL	Chlamydia Screening in Women	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X	X					X
HEDIS_CIS	Childhood Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_COL	Colorectal Cancer Screening (COL)	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year with a 10 Year Look-back	Annually	June 30th			X					
HEDIS_COU	Risk of Chronic Opioid Use (COU)	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X			X				X
HEDIS_CRE	Cardiac Rehabilitation	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_CWP	Appropriate Testing for Pharyngitis	HEDIS Measure	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X							
HEDIS_EED	Eye Exam for Patients With Diabetes (EED)	HEDIS Measure formerly part of HEDIS_CDC, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th	X							X
HEDIS_FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure		Calendar Year	Annually	June 30th	X	X	X	X				X

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HEDIS_FUH	Follow-Up After Hospitalization For Mental Illness	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure		January 1 to December 1 of measurement year	Annually	June 30th	X	X	X					X
HEDIS_FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure		January 1 to December 1 of measurement year	Annually	June 30th	X							X
HEDIS_FUM	Follow-Up After Emergency Department Visit for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure		Calendar Year	Annually	June 30th	X	X	X					X
HEDIS_FVA	Flu Vaccinations for Adults Ages 18–64 (FVA)	HEDIS Measure Collected through the CAHPS Health Plan Survey, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					
HEDIS_HBD	Hemoglobin A1c Control for Patients With Diabetes (HBD)	HEDIS Measure formerly part of HEDIS_CDC. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th	X		X					X
HEDIS_HDO	Use of Opioids at High Dosage	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X			X				X
HEDIS_IET	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure		Calendar Year	Annually	June 30th	X		X	X				X
HEDIS_IMA	Immunizations for Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_KED	Kidney Health Evaluation for Patients with Diabetes	HEDIS Measure, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th	X							X
HEDIS_LBP	Use of Imaging Studies for Low Back Pain	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							

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HEDIS_LSC	Lead Screening in Children	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th		X							X
HEDIS_MSC	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	HEDIS Measure Collected through the CAHPS Health Plan Survey	Measure		Calendar Year	Annually	June 30th	X		X						
HEDIS_PCE	Pharmacotherapy Management of COPD Exacerbation	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X								
HEDIS_PCR	Plan All-Cause Readmissions	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X						X
HEDIS_POD	Pharmacotherapy for Opioid Use Disorder	HEDIS Measure	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X								X
HEDIS_PPC	Prenatal and Postpartum Care	HEDIS Measure, also utilized for CMS Core Sets. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th	X	X	X						X
HEDIS_PRS-E	Prenatal Immunization Status	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X								
HEDIS_RDM	Race/Ethnicity Diversity of Membership	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X								
HEDIS_SAA	Adherence to Antipsychotics for Individuals with Schizophrenia	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X						X

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HEDIS_SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_SPC	Statin Therapy for Patients with Cardiovascular Disease	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_SPD	Statin Therapy for Patients with Diabetes	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					X
HEDIS_UOP	Use of Opioids from Multiple Providers	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X			X				X
HEDIS_UR1	Appropriate Treatment for Upper Respiratory Infection	HEDIS Measure	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X							
HEDIS_W30	Well-Child Visits in the first 30 Months of Life	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th		X				X		X

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HEDIS_WCC	Weight Assessment and Counseling	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_WCV	Child and Adolescent Well-Care Visits	HEDIS Measure, also utilized for CMS Core Sets Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th		X				X		X
HRA.08	Successful Completion of MCO Health Risk Assessment	Percent of members for whom the MCO shows completion of a health risk assessment during the measurement year, as of the last day of the measurement year. This measure excludes members newly eligible for Medicaid in the last three months of the measurement year.	Measure		Year	Quarterly	2 Months after end of Measurement Period								
HRA.09	Health Risk Assessment Narrative Report	Narrative description of the MCO's efforts to assure 25% of the members have a completed Health Risk Assessment including reasons for not achieving the contract standard.	Narrative Report		Quarter	Quarterly	2 Months after end of Measurement Period								
IMDDISCHARGE.01	State of NH IMD Hospital Discharges - Member Received Discharge Instruction Sheet	Count and percent of discharges from a State of NH IMD Hospital where the member received a discharge instruction sheet upon discharge.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
IMDDISCHARGE.02	State of NH IMD Hospital Discharges - Discharge Plan Provided to Aftercare Provider Within 7 Calendar Days of Member Discharge	Count and percent of members discharged from a State of NH IMD Hospital where the discharge progress note was provided to the aftercare provider within 7 calendar days of member discharge. The contract standard = at least ninety percent (90%) of members discharged.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X

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IMDDISCHARGE.03	State of NH IMD Hospital Discharges - New CMHC Patient Had Intake Appointment with CMHC within 7 Calendar Days of Discharge	Count and percent of State of NH IMD Hospital discharges where the patient had an intake appointment with a NH Community Mental Health Center (NH CMHC) within 7 calendar days of discharge AND who were new to the NH CMHC system.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
IMDDISCHARGE.04	State of NH IMD Hospital Discharges - MCO Contacts and Contact Attempts	Count and percent of members discharged from a State of NH IMD Hospital during the measurement period, where the MCO either successfully contacted the member, or attempted to contact the member at least 3 times, within 3 business days of discharge.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
IMDDISCHARGE.05	Follow-up Visit after Discharge from a State of NH IMD Hospital - Within 7 Days of Discharge	Count and percent of member discharges from a State of NH IMD Hospital where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge, by age group and CMHC eligibility. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
IMDDISCHARGE.06	Follow-up Visit after Discharge from a State of NH IMD Hospital - Within 30 Days of Discharge	Count and percent of member discharges from a State of NH IMD Hospital where the member had at least one follow-up visit with a mental health practitioner within 30 calendar days of discharge, by age group and CMHC eligibility. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
IMDREADMIT.01	Readmissions to State of NH IMD Hospital - Within 30 Days of Discharge	Count and percent of member readmissions to a State of NH IMD Hospital within 30 days of discharge, by age group and CMHC eligibility.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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IMDREADMIT.02	Readmissions to State of NH IMD Hospital - Within 180 Days of Discharge	Count and percent of member readmissions to a State of NH IMD Hospital within 180 days of discharge, by age group and CMHC eligibility.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
IMDREADMIT.03	ED Visits for Mental Health Preceded by a State of NH IMD Hospital Stay in Past 30 Days	Count and percent of mental health related emergency department visits that were preceded within 30 days by a discharge from a State of NH IMD Hospital and not followed by a readmission to a State of NH IMD Hospital, for continuously enrolled Medicaid members, by age group and CMHC eligibility. The primary diagnosis for the ED visit must be mental health related.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
INLIEUOF.01	In Lieu of Services Report	A narrative report describing the cost effectiveness of each approved In Lieu of Service by evaluating utilization and expenditures.	Narrative Report		Agreement Year	Annually	November 1st						X		X

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INPASC.04	Inpatient Hospital Utilization - Ambulatory Care Sensitive Conditions	Count and percent of Inpatient hospital utilization for ambulatory care sensitive conditions per 1,000 adult member months, by subpopulation. This measure includes the following ambulatory care sensitive conditions, as defined for the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators Overall Composite (PQI 90): Diabetes Short-Term Complications (PQI #1); Diabetes Long-Term Complications (PQI #3); Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (PQI #5); Hypertension (PQI #7); Heart Failure (PQI #8); Dehydration (PQI #10); Bacterial Pneumonia (PQI #11); Urinary Tract Infection (PQI #12); Uncontrolled Diabetes (PQI #14); Asthma in Younger Adults (PQI #15); and Lower-Extremity Amputation among Patients with Diabetes (PQI #16).	Measure	General	Agreement Year	Annually	4 Months after end of Measurement Period					X	X		
INTEGRITY.01	Program Integrity Plan	Plan for program integrity which shall include, at a minimum, the establishment of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse, as required in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438.	Plan		Agreement Year	Annually	May 1st, Upon Revision						X		
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	Standard template listing specific members being locked in to a pharmacy for the measurement period.	Table		Month	Monthly	1 Month after end of Measurement Period								X
LOCKIN.03	Pharmacy Lock-in Activity Summary	Standard template with aggregate data related to pharmacy lock-in enrollment and changes during the measurement period.	Table		Month	Monthly	1 Month after end of Measurement Period								X

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MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	MCO shall annually submit its managed care information system (MCIS) plans to ensure continuous operation of the MCIS. This should include the MCOs risk management plan, systems quality assurance plan, confirmation of 5010 compliance and companion guides, and confirmation of compliance with IRS publication 1075.	Plan		Agreement Year	Annually	June 1st								X
MEMCOMM.01	Member Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound member calls answered by a live voice within 30 seconds, by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period					X	X		X
MEMCOMM.03	Member Communications: Calls Abandoned	Count and percent of inbound member calls abandoned while waiting in call queue, by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period					X	X		X
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	Count and percent of inbound member telephone inquiries connected to a live person by reason for inquiry. Reasons include A: Benefit Question Non-Rx, B: Rx-Question, C: Billing Issue, D: Finding/Changing a PCP, E: Finding a Specialist, F: Complaints About Health Plan, G: Enrollment Status, H: Material Request, I: Information/Demographic Update, J: Giveaways, K: Other, L: NEMT Inquiry	Measure		Month	Monthly	1 Month after end of Measurement Period							X	X
MEMCOMM.24	Member Communications: Calls Returned by the Next Business Day	Count and percent of member voicemail or answering service messages responded to by the next business day.	Measure		Month	Monthly	1 Month after end of Measurement Period						X		X

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MEMINCENTIVE.01	Member Incentive Table	Standard template reporting detail around member incentives including category, number of payments, and dollar value of payments for member incentive payments during the measurement period. Annually the MCO will include a statistically sound analysis of the member incentive program and identify goals and objectives for the following year.	Table		Quarter	Quarterly	2 Months after end of Measurement Period								X
MEMINCENTIVE.02	Member Incentive Plan	Annual member incentive plan including goals and objectives associated with the MCOs member incentive strategy.	Plan		Agreement Year	Annually	May 1st								X
MHACT.01	Adult CMHP Assertive Community Treatment (ACT) Service Utilization	Count and percent of eligible Community Mental Health Program (CMHP) members receiving at least one billed Assertive Community Treatment (ACT) service in each month of the measurement period.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
MHDISCHARGE.01	Follow-up Visit after Community Hospital, APRT Facility or DRF Discharge for Mental Health-Related Conditions - Within 7 Days of Discharge	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF) with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
MHDISCHARGE.02	Follow-up Visit after Community Hospital, APRT Facility or DRF Discharge for Mental Health-Related Conditions - Within 30 Days of Discharge	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF) with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 30 calendar days of discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHEDBRD.01	Emergency Department Psychiatric Boarding Table	Standard template broken out by children and adults with the number of members who awaited placement in the emergency department or medical ward for 24 hours or more. Summary totals by disposition of those members who were waiting for placement; the average length of stay while awaiting placement; and the count and percent of those awaiting placement who were previously awaited placement within the prior 30, 60 and 90 days.	Table		Month	Monthly	1 Month after end of Measurement Period								X
MHREADMIT.03	Mental Health Readmissions: Service Utilization Prior to Readmission	For Members for the measurement month who represented a readmission within 180 days, the MCO will report on the mental health and related service utilization that directly preceded readmission in accordance with Exhibit O.	Table		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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MHREADMIT.04	Readmissions for Mental Health Conditions within 30 Days of Discharge - Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF), with a primary diagnosis for a mental health-related condition, readmitted for a mental-health related condition within 30 days of a previous discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHREADMIT.05	Readmissions for Mental Health Conditions within 180 days of Discharge - Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF), with a primary diagnosis for a mental health-related condition, readmitted for a mental-health related condition within 180 days of a previous discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHREADMIT.06	Readmissions for Mental Health Conditions within 30 Days of Discharge - State of NH IMD Hospitals, Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from either a State of NH IMD Hospital, community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or Designated Receiving Facility (DRF) with a primary diagnosis for a mental health condition, readmitted to any of these facilities for a mental health-related condition within 30 days, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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MHREADMIT.07	Readmissions for Mental Health Conditions within 180 Days of Discharge - State of NH IMD Hospitals, Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from either a State of NH IMD Hospital, community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or Designated Receiving Facility (DRF) with a primary diagnosis for a mental health condition, readmitted to any of these facilities for a mental health-related condition within 180 days, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHSUICIDE.01	Zero Suicide Plan	Plan for incorporating the "Zero Suicide" model promoted by the National Action Alliance for Suicide Prevention (US Surgeon General) with providers and beneficiaries.	Plan		Agreement Year	Annually	May 1st								X
MHTOBACCO.01	Adult and Youth CMHP Eligible Members: Smoking Status	Count and percent of Community Mental Health Program (CMHP) Eligible Adult and Youth Members 12-17 and 18 and older who are current tobacco users.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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MLR.01	Medical Loss Ratio Report	Standard template developed by DHHS actuaries that includes all information required by 42 CFR 438.8(k), and as needed other information, including, but not limited to: <ul style="list-style-type: none"> • Total incurred claims; • Expenditures on quality improvement activities; • Expenditures related to activities compliant with the program integrity requirements; • Non-claims costs; • Premium revenue; • Taxes; • Licensing fees; • Regulatory fees; • Methodology for allocation of expenditures; • Any credibility adjustment applied; • The calculated MLR; • Any remittance owed to New Hampshire, if applicable; • A comparison of the information reported with the audited financial report; • A description of the aggregate method used to calculate total incurred claims; and • The number of Member months. [42 CFR 438.8(k)(1)(i)-(xiii); 42 CFR 438.608(a)(1)-(5); 42 CFR 438.608(a)(7)-(8); 42 CFR 438.608(b); 42 CFR 438.8(i)] 	Table		Quarter	Quarterly	9 Months after end of Measurement Period						X		

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MONTHLYOPS.01	Monthly Operations Report	This report will include details about the employment status of Key Personnel required by the MCO contract.	Table		Month	Monthly	1 Month after end of Measurement Period								X
MSQ.01	Medical Services Inquiry Letter	Standard template log of Inquiry Letters sent related to possible accident and trauma. DHHS will require a list of identified members who had a letter sent during the measurement period with a primary or secondary diagnosis code requiring an MSQ letter. For related ICD Codes please make a reference to Trauma Code Tab in this template.	Table		Month	Monthly	1 Month after end of Measurement Period						X		X
NEMT.15	NEMT Requests Delivered by Type of Medical Service	Count and percent of Non-Emergent Medical Transportation (NEMT) requests delivered, by type of medical service. Types include: A: Hospital, B: Medical Provider, C: Mental Health Provider, D: Dentist, E: Pharmacy, F: Methadone Treatment, G: Other	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
NEMT.18	Results of Scheduled NEMT Trips by Outcome	Percent of Non-Emergent Medical Transportation contracted transportation provider and wheelchair van requests scheduled for all rides requested during the measure data period by outcome of the ride. This measure includes methadone treatment rides. Exclude all Family and Friends Mileage Reimbursement Program legs from this measure. Outcomes include: A: Member cancelled or rescheduled, B: Transportation provider cancelled or rescheduled, C: Member no show, D: Transportation provider no show, E: Other reason trip wasn't made, F: Delivered and G: Unknown if trip occurred.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X

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NEMT.22	Family and Friends Program NEMT Rides	Count and percent of Non-Emergent Medical Transportation one-way rides delivered through the Family and Friends Mileage program.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
NEMT.24	Scheduled NEMT Trips Delivered On Time	Count and percent of Non-Emergent Medical Transportation (NEMT) contracted transportation provider and wheelchair van requests scheduled and delivered during the measurement period, with an outcome of delivered on time. The following exclusions apply: Exclude Methadone treatment rides. Exclude rides provided by Easter Seals.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
NEMT.25	NEMT Network Adequacy Report	TBD - This will be quarterly by mode of transportation and county. Will work through specifications with MCOs and transportation brokers.	Table		Quarter	Quarterly	TBD								X
NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Annual Filing	Standard template for the MCO to report on the adequacy of its provider network and equal access, including time and distance standards.	Table		Calendar Year	Annually	45 Calendar Days after end of Measurement Period			X	X	X			
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	MCO provider exceptions to network adequacy standards. Exceptions should include necessary detail to justify the exception and a detailed plan to address the exception.	Table		Calendar Year	Annually, Ad hoc as warranted	45 Calendar Days after end of Measurement Period			X	X	X			
NETWORK.11	Access to Care Provider Survey	Results of the MCO annual timely access to care provider survey reported in a standard template.	Table		Agreement Year	Annually	45 Calendar Days after end of Measurement Period			X	X	X			

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PDN.04	Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for child members (age 0-20 years of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
PDN.05	Private Duty Nursing: Authorized Hours for Adults Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for adult members (age 21 and older of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
PDN.07	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Year to Date detail related to members receiving private duty nursing services.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X
PDN.08	Private Duty Nursing: Network Adequacy Report	Standard template measuring the adequacy of the MCOs network for delivering private duty nursing services	Narrative Report		Quarter	Quarterly	TBD								X
PHARM_PDC.01	Proportion of Days Covered - Diabetes All Class Rate (PDC-DR)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Diabetes All Class.	Measure		Calendar Year	Annually	April 30th								X

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PHARM_PDC.02	Proportion of Days Covered - Renin Angiotensin System Antagonists (PDC-RASA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Renin Angiotensin System Antagonists.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.03	Proportion of Days Covered - Statins (PDC-STA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for statins.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.04	Proportion of Days Covered - Beta-Blockers (PDC-BB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for beta-blockers.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.05	Proportion of Days Covered - Calcium Channel Blockers (PDC-CCB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for calcium channel blockers.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.10	Proportion of Days Covered (PDC) - Adherence to Direct-Acting Oral Anticoagulants (PDC-DOAC)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to direct-acting oral anticoagulants.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.11	Proportion of Days Covered - Adherence to Long-Acting Inhaled Bronchodilator Agents in COPD Patients (PDC-COPD)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to long-acting inhaled bronchodilator agents in COPD patients.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.12	Proportion of Days Covered - Antiretroviral Medications (PDC-ARV)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for antiretroviral medications.	Measure		Calendar Year	Annually	April 30th								X

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PHARM_PDC.13	Proportion of Days Covered - Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis (PDC-MS)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused disease modifying agents used to treat Multiple Sclerosis.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.14	Adherence to Non-Infused Biologic Medications Used to Treat Rheumatoid Arthritis (PDC-RA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused biologic medications used to treat rheumatoid arthritis.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.15	Proportion of Days Covered Composite (PDC-CMP)	The composite percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year for: diabetes medications, RAS antagonists, and statins. This is a composite health plan performance measure that combines rates from the following component measures: • Component 1: Proportion of Days Covered: Diabetes All Class (PDC-DR) • Component 2: Proportion of Days Covered: Renin Angiotensin System Antagonist (PDC-RASA) • Component 3: Proportion of Days Covered: Statins (PDC-STA)	Measure		Calendar Year	Annually	April 30th								X
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Count and percent of opioid prescription fills that were prior authorized to meet the NH DHHS Morphine Equivalent Doses (MED) Prior Authorization policy in effect for the measurement period, including members with cancer or other terminal illnesses.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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PHARMQI.10	Child Psychotropic Medication Monitoring Report	Standard template of patient level and aggregated data related to children 0-18 with multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications. Totals are broken out by age categories and whether the child was involved with the Division for Children, Youth, and Families.	Table		Quarter	Quarterly	1 Month after end of Measurement Period								X
PHARMUTLMGT.02	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Count and percent of prescriptions filled for generic drugs adjusted for preferred PDL brands. (To adjust for PDL, remove brand drugs which are preferred over generics from the multi-source claims; and remove their generic counterparts from generic claims).	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
PHARMUTLMGT.03	Pharmacy Utilization Management: Generic Drug Substitution	Count and percent of prescriptions filled where generics were available, including multi-source claims.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
PHARMUTLMGT.04	Pharmacy Utilization Management: Generic Drug Utilization	Count and percent of prescriptions filled with generic drugs out of all prescriptions filled.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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PMP.01	Program Management Plan	<p>The Program Management Plan (PMP) is a document used to provide an overview of the managed care organization's (MCO) delivery of the program as it operates in New Hampshire. Details and specifications are listed below as the PMP includes key topics and associated descriptions. After the initial year the MCO should submit a certification of no change or provide a red-lined copy of the updated plan.</p> <p>Table of Contents</p> <p>I. Executive Summary</p> <p>II. Organizational structure: a. Staffing and contingency plans; b. Corporation Relationships and Structure</p> <p>III. Business Operations: a. Overview; b. Hours of operation; c. Holidays and emergency closing notification</p> <p>IV. Committees and workgroups: a. General; b. Member Advisory Board; c. Provider Advisory Board</p> <p>V. Communication: a. General; b. Vendor relationships; c. Member management; d. Providers</p> <p>VI. Systems: a. Software and information management; b. Process improvement methods; c. Project management; d. Evaluation methods</p> <p>VII. Providers: a. Management and communication; b. Relationships</p> <p>VIII. Services: a. Pharmacy; b. Behavioral Health; c. Substance Use Disorder; d. Durable medical equipment; e. Special populations; f. Transportation; g. Other Benefits</p> <p>IX. Program Operations: a. Utilization management; b. Grievance and Appeals; c. Care Management</p> <p>X. Community Engagement</p>	Plan	Agreement Year	Annually	May 1st								X
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POLYPHARM.04	Polypharmacy Monitoring: Children with 4 or More Prescriptions for 60 Consecutive Days	Count and percent of child Medicaid members with four (4) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter, by age group: A. Age 0-5 years, B. Age 6-17 years. A PDC of 80 percent or Higher indicates compliance with treatment.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
POLYPHARM.06	Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	Count and percent of adult Medicaid members with five (5) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter by age group: A. Age 18-44, B. Age 45-64 years. A PDC of 80 percent or Higher indicates compliance with treatment.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
PROVAPPEAL.01	Resolution of Provider Appeals Within 30 Calendar Days	Count and percent of provider appeals resolved within 30 calendar days of the Final Provider Appeal Filing Date, for Final Provider Appeals received during the measure data period.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period						X		
PROVAPPEAL.02	Provider Appeals Log	Standard template log of appeals with detail on all provider appeals including the MCO response to the appeal for provider appeals filed within the measure data period.	Table		Quarter	Quarterly	2 Months after end of Measurement Period						X		
PROVCOMM.01	Provider Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound provider calls answered by a live voice within 30 seconds by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period								X

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PROVCOMM.03	Provider Communications: Calls Abandoned	Count and percent of inbound provider calls abandoned either while waiting in call queue by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period								X
PROVCOMM.07	Provider Communications: Reasons for Telephone Inquiries	Count and percent of inbound provider telephone inquiries connected to a live person by reason for Inquiry. Reasons include A: Verifying Member Eligibility, B: Billing / Payment, C: Service Authorization, D: Change of Address, Name, Contact info, etc. E: Enrollment / Credentialing, F: Complaints About Health Plan, G: Other.	Measure		Month	Monthly	1 Month after end of Measurement Period								X
PROVCOMM.08	Provider Communications: Calls Returned by Next Business Day	Count and percent of provider voicemail or answering service messages returned by the next business day.	Measure		Month	Monthly	1 Month after end of Measurement Period								X
PROVCOMPLAINT.01	Provider Complaint and Appeals Log	Standard template providing a quarterly report of all provider complaints and appeals in process during the quarter.	Table		Quarter	Quarterly	2 Months after end of Measurement Period						X		
PROVPREVENT.01	Hospital-Acquired and Provider-Preventable Condition Table	Standard template that identifies denials or reduced payment amounts for hospital-acquired conditions and provider preventable conditions. Table will include MCO claim identifier, provider, date of service, amount of denied payment or payment reduction and reason for payment denial or reduction.	Table		Annual	Annually	April 30th						X		

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PROVPRIV.01	Behavioral Health Written Consent Report	Narrative reporting of the results of the MCO review of a sample of case files where written consent was required by the member to share information between the behavioral health provider and the primary care provider. In these sample cases, the MCO will determine if a release of information was included in the file. The MCO shall report instances in which consent was not given, and, if possible, the reason why.	Narrative Report		Agreement Year	Annually	4 Months after end of Measurement Period						X		X
PROVTERM.01	Provider Termination Log - including Program Integrity Elements	Standard template log of providers who have given notice, been issued notice, or have left the MCOs network during the measurement period, including the reason for termination. Number of members impacted, impact to network adequacy, and transition plan if necessary.	Table		Month	Monthly	TBD						X		X
QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Plan	Annual description of the MCO's organization-wide QAPI program structure. The plan will include the MCO's annual goals and objectives for all quality activities. The plan will include a description of the mechanisms to detect under and over utilization, assess the quality and appropriateness of care for Member with special health care needs and disparities in the quality of and access to health care (e.g. age, race, ethnicity, sex, primary language, and disability); and process for monitoring, evaluating and improving the quality of care for members receiving behavioral health services.	Plan		Calendar Year	Annually	November 30th							X	

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
QAPI.02	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	The report will describe completed and ongoing quality management activities, performance trends for QAPI measures identified in the QAPI plan; and an evaluation of the overall effectiveness of the MCO's quality management program including an analysis of barriers and recommendations for improvement.	Narrative Report		Calendar Year	Annually	February 28th						X		
SDH.XX	Social Determinants of Health	Placeholder for additional measures to show MCO impact on social determinants of health (SDH)	Measure		TBD	TBD	TBD								X
SERVICEAUTH.01	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Count and percent of medical service, equipment, and supply service authorization determinations for urgent requests made within 72 hours after receipt of request for requests made during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.03	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	Count and percent of medical service, equipment, and supply service, authorization determinations for new routine requests made within 14 calendar days after receipt of request for requests made during the measure data period. Exclude authorization requests that extend beyond the 14 day period due to the following: The member requests an extension, or The MCO justifies a need for additional information and the extension is in the member's interest. Exclude requests for non-emergency transportation from this measure.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SERVICEAUTH.04	Pharmacy Service Authorization Timely Determination Rate	Count and percent of pharmacy service authorization determinations made during the measurement period where the MCO notified the provider via telephone or other telecommunication device within 24 hours of receipt of the service authorization request.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category by State Plan, 1915b Waiver, and Total Population	Standard template summary of service authorization determinations by type and benefit decision for request received during the measure data period.	Table		Quarter	Quarterly	2 Months after end of Measurement Period				X				
SERVICEAUTH.13	Medical Service, Equipment and Supply Post-Delivery Service Authorization Timely Determination Rate	Count and percent of post-delivery authorization determinations made within 30 calendar days of receipt of routine requests, for medical services, equipment, and supply services. Exclude requests for non-emergency transportation from this measure.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.14	Service Authorization Denials for Waiver & Non-HCBC Waiver Populations	Rate of service authorizations denied during the measurement period, broken out by the fol03 - Lowing waiver groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.15	Service Authorizations: Physical, Occupational & Speech Therapy Service Authorization Denials by Waiver & Non-HCBC Waiver Populations	Rate of physical, occupational and speech therapy service authorizations denied during the measurement period, broken out by the fol03 - Lowing groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SMI_CMS.26	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SMI by Subpopulation	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period. (CMS 1115 SMI DEMONSTRATION Metric #26)	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				
SMI_CMS.30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who are age 18 years and older, and completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication. (CMS 1115 SMI DEMONSTRATION Metric #30)	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				
SUBROGATION.01	Subrogation Report	Standard template identifying information regarding cases in which DHHS has a Subrogation lien. DHHS will inform the MCO of claims related to MCO subrogation cases that need to be included in the report.	Table		Month	Monthly	15 Calendar Days after end of Measurement Period						X		X
SUD.27	Member Access to Clinically Appropriate Services as Identified by ASAM Level of Care Determination Table	Standard template reporting members receiving ASAM SUD services as identified by initial or subsequent ASAM level of care criteria determination within 30 days of the screening. The table will include a file review of a sample of members who received an ASAM SUD service during the measurement period. Age breakouts are 0-17, 18+; exclude duals.	Table		Calendar Year	Annually	6 Months after end of Measurement Period				X				X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.39	High Opioid Prescribing Provider Monitoring Report	Narrative reporting of the MCO's identification of providers with High opioid prescribing rates and efforts to follow up with providers. The report should include the MCO's operational definition of a provider with a High opioid prescribing rate, the process for identifying and following up with providers. The report should include aggregate data about the number of providers that are identified and the follow up. Age breakouts are 0-17, 18+; exclude duals.	Narrative Report		Agreement Year	Annually	2 Months after end of Measurement Period								X
SUD.42	MCO Contacts and Contact Attempts Following ED Discharges for SUD	Count and percent of member Emergency Department discharges with an SUD principal diagnosis during the measurement period, where the MCO either successfully contacted the member within 3 business days of discharge, or attempted to contact the member at least 3 times within 3 business days of discharge, by age, 0 to 17 years and 18 years or older.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
SUD.52	Member Access to SUD Services following SUD Assessment and Diagnosis	Percent of all Medicaid members with one or more SUD Treatment Services during the measurement period and a 60-day Negative Diagnosis History prior to the first treatment session who had a SUD Assessment within 3 days of the Initial SUD Treatment Service or a SUD Assessment over the course of 3 SUD treatment service sessions delivered within 30 days of the Initial Treatment Service. This assessment can be with the same provider or a different provider.	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD_CMS.05	SUD Diagnosis Treated in an IMD by Subpopulation	Count and percent of Medicaid members with a claim for residential treatment for substance use disorder (SUD) in an institution for mental disease (IMD) during the reporting year, by SUD IMD subpopulation. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #5)	Measure		Agreement Year	Annually	4 Months after end of Measurement Period				X				X
SUD_CMS.25	Readmissions among Members with SUD by Subpopulation	The count and percent of acute inpatient stays among Medicaid members with substance use disorder (SUD), during the measurement period, followed by an acute readmission within 30 days, by SUD IMD subpopulation.	Measure		Agreement Year	Annually	4 Months after end of Measurement Period				X				X
SUD_CMS.32_CY	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SUD by Subpopulation	Count and percent of Medicaid members with substance use disorder (SUD) who had an ambulatory or preventive care visit during the measurement period by SUD IMD Waiver subpopulation. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #32)	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				X
SUD_CMS.36	Average Length Of Stay In An IMD For SUD by Subpopulation	Average length of stay (in days) in an Institute for Mental Disease (IMD) during the measurement year for Medicaid members who had substance use disorder (SUD) treatment, by SUD IMD subpopulation.	Measure		Agreement Year	Annually	4 Months after end of Measurement Period				X				X
SUDAUDIT.01	SUD Record Audits	All completed audit tools for each of the successive periods under review (PUR).	Table		6 Months	Semi-Annually	January 15th and July 15th								X
SUDAUDIT.02	SUD Record Audit Provider Level Summaries	Standard template that captures a summary of provider level findings from average aggregated scores	Table		6 Months	Semi-Annually	January 31st and July 31st								X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUDAUDIT.03	SUD Record Audits – Opioid Treatment Providers	Case level data from the MCOs audit of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).	Table		TBD	TBD	TBD								X
SUDAUDIT.04	SUD Record Audit Opioid Treatment Providers Provider Level Summaries	Standard template that captures a summary of provider level findings from average aggregated scores for the MCOs audit of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).	Table		TBD	TBD	TBD								X
TIMELYCRED.01	Timely Provider Credentialing - PCPs	The percent of clean and complete provider (PCP) applications for which the MCO or subcontractor credentials the PCP and the provider is sent notice of enrollment within 30 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHH Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
TIMELYCRED.02	Timely Provider Credentialing - Specialty Providers	The percent of clean and complete specialty provider applications for which the MCO or credentials the specialty provider and the provider is sent notice of enrollment within 45 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure. Specialty providers include Durable Medical Equipment (DME) and Optometry providers.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X
TOBACCO.01	Annual Report of MCO Tobacco Cessation Program Offerings, Operations, and Utilization	The report captures information about MCO Tobacco Cessation offerings, operations and utilization on an annual basis. For each annual submission, submit an updated clean report and a redline version of the updated report.	Narrative Report		Agreement Year	Annually	4 Months After the End of the Measurement Period								X
TOBACCO.04	Tobacco Cessation Activity Report	Report reflecting the volume of members utilizing different tobacco cessation supports such as counseling, medication, and messaging.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X
TOBACCO.XX	Tobacco Use and Cessation	Placeholder for additional measures to show MCO impact on tobacco use and cessation.	Measure		TBD	TBD	TBD								X
TPLCOB.01	Coordination of Benefits: Costs Avoided Summary Report	Standard template reporting total charge and potential paid amount for claims denied due to other benefit coverage by insurance type for the measure data period.	Table		Quarter	Quarterly	45 Calendar Days after end of Measurement Period								X
TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	Standard template log of COB medical benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans, and workers compensation.	Table		Quarter	Quarterly	45 Calendar Days after end of Measurement Period								X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Standard template log of COB pharmacy benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans.	Table		Quarter	Quarterly	45 Calendar Days after end of Measurement Period								X
UMSUMMARY.03	Medical Management Committee	MCO shall provide copies of the minutes from each of the MCO Medical Utilization Management committee (or the MCO's otherwise named committee responsible for medical utilization management) meetings.	Narrative Report		Agreement Year	Annually	2 Months after end of Measurement Period						X		X

State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify GRANITE STATE HEALTH PLAN, INC. is a New Hampshire corporation registered on March 14, 2012. I further certify that articles of dissolution have not been filed with this office; and the attached is a true copy of the list of documents on file in this office.

INFORMATION REGARDING ANNUAL REPORTS AND/OR FEES MUST BE OBTAINED FROM THE NEW HAMPSHIRE INSURANCE DEPARTMENT.

Business ID: 667495

Certificate Number: 0006235856



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 23rd day of May A.D. 2023.

A handwritten signature in black ink, appearing to read "D. Scanlan", is written over a faint circular stamp.

David M. Scanlan
Secretary of State



State of New Hampshire

Department of State



Business Name : Granite State Health Plan, Inc.

Business ID : 667495

Filing History

Filing#	Filing Date	Effective Date	Filing Type	Annual Report Year
0005664059	02/08/2022	02/08/2022	Amendment	N/A
0005659865	02/04/2022	02/04/2022	Registered Agent Change	N/A
0002911553	03/14/2012	03/14/2012	Business Formation	N/A

Trade Name Information

Business Name	Business ID	Business Status
New Hampshire Healthy Families	688160	Active
NH Healthy Families	743061	Active

Name History

Name	Name Type
No Name Changes found for this business.	

Principal Information

Name	Title
No Principal Information found for this business.	


CERTIFICATE OF AUTHORITY

I, Joel B. Samson, hereby certify that I am the duly appointed Secretary of Granite State Health Plan, Inc., a New Hampshire corporation (the "Corporation").

I further certify that Clyde A. White, President and Chief Executive Officer of the Corporation, is authorized to sign on behalf of the Corporation any and all agreements and to execute any and all contracts, documents and instruments necessary to bind the Corporation.

I further certify that the authority given to the individual named above shall remain in full force and effect until this Certificate of Authority is amended by the Corporation.

IN WITNESS WHEREOF, I have subscribed my name as Secretary of the Corporation on this 30th day of May 2023.



Joel B. Samson, Secretary



CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
12/01/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services Central, Inc. St. Louis MO Office 4220 Duncan Avenue Suite 401 St. Louis MO 63110 USA	CONTACT NAME:	
	PHONE (A/C. No. Ext): (866) 283-7122	FAX (A/C. No.): (800) 363-0105
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	
INSURED Granite State Health Plan, Inc. c/o Centene Corporation 7700 Forsyth Blvd. Suite 600 St. Louis MO 63105 USA	INSURER A: American Zurich Ins Co	40142
	INSURER B: Zurich American Ins Co	16535
	INSURER C: XL Specialty Insurance Co	37885
	INSURER D:	
	INSURER E:	
	INSURER F:	

Holder Identifier:

COVERAGES **CERTIFICATE NUMBER:** 570096628379 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
B	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GENL AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:			GL0014909904 SIR applies per policy terms & conditions	06/01/2022	06/01/2023	EACH OCCURRENCE \$2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$1,000,000 MED EXP (Any one person) \$10,000 PERSONAL & ADV INJURY \$2,000,000 GENERAL AGGREGATE \$4,000,000 PRODUCTS - COMPOP AGG \$4,000,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
C	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION			US00068524LI22A SIR applies per policy terms & conditions	06/01/2022	06/01/2023	EACH OCCURRENCE \$5,000,000 AGGREGATE \$5,000,000 Retention \$10,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below		N/A	WC647833309	06/01/2022	06/01/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH E.L. EACH ACCIDENT \$1,000,000 E.L. DISEASE-EA EMPLOYEE \$1,000,000 E.L. DISEASE-POLICY LIMIT \$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Certificate No: 570096628379

CERTIFICATE HOLDER State of NH Department of Health and Human Services 129 Pleasant Street Concord NH 03301-3857 USA	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE
---------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT**

License No: 89278606

Presents that Granite State Health Plan, Inc.
is hereby authorized to transact **HMO** lines of Insurance
in accordance with State Statute RSA 420-B
Exclusions: 8.4 Restricted to Medicaid Managed Care

Effective Date: 06/15/2023
Expiration Date: 06/14/2024



Christopher R. Nicolopoulos
Christopher R. Nicolopoulos, Esq.
Commissioner of Insurance

DEC 15 '22 PM 12:00 RCVD

ARC

13A



**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES**

Lori A. Shibinette
Commissioner

Henry D. Lipman
Director

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

December 12, 2022

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into retroactive amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$245,113,188 from \$4,473,715,686 to \$4,718,828,874 (for the period since contract inception September 2019), with no change to the completion date of August 31, 2024, and effective retroactive to July 1, 2022, upon Governor and Council approval. All terms and conditions of the contract and prior amendment not inconsistent with this Amendment remain in full force and effect. The federal fund share comprises 81% of the price limitation increase, the other non-federal fund share is 12%, and the general fund is 7% from the previous Amendment.

Funding sources are as follows:

	Federal	Other / Agency Income	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 128-AA:3, I)	0%
Child Health Insurance Program (CHIP)	69.34%	1.07%	29.59%
Standard Medicaid Population (Medicaid Care Management)	53.6%	22.4%	24.00%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of FMAP for the Children's Health Insurance Program (CHIP) population remains available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020 (Item #8), January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), as

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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amended on December 08, 2021 (Item #6-1), and as amended on June 15, 2022 (Item # Tabled Item 20A).

Funds are available in the accounts outlined in the attached fiscal details and are available in the State Fiscal Year (SFY) 2023, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

The Centers for Medicare & Medicaid Services (CMS) requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2023.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request is Retroactive because it covers the rating period of July 1, 2022 through June 30, 2023. The methodology used to develop the previous Amendment #8 SFY 2023 capitation rates is largely consistent with the capitation rate methodology in this Amendment #9.

The federal Public Health Emergency (PHE) continues to have an impact on program costs. In order for states to receive the 6.2% enhanced Federal Medical Assistance Percentage (FMAP) the Families First Coronavirus Response Act requires continuous enrollment by states for individuals who were or became Medicaid eligible since March 13, 2020 through at least April 2023. The PHE end date was not noticed on November 12, 2022, so an end of the PHE in January is off the table unless there is Congressional intervention. The PHE, therefore, is likely to run through April 2023.

As of the beginning of December, the NH Medicaid program has 100,481 individuals protected from disenrollment due to continuous enrollment, out of an enrollment of over 246,616 as of December 5, 2022. Absent the continuous enrollment requirement, as of November 30, 2022, more than 29,000 people are known to be ineligible based on completed redeterminations of eligibility (or nearly 12% of current enrollees). Another nearly 35,000 individuals are potentially ineligible since they have not yet completed an annual redetermination of eligibility, which is not required during the PHE. Over 36,000 are both overdue in completing a redetermination and potentially ineligible based on yet to be verified information available to DHHS. Any material disenrollment is unlikely in this rate year, and is likely to begin no earlier than May 1, 2023.

While the State continues to receive 6.2% enhanced FMAP on certain Medicaid expenditures, the enhanced federal payment excludes the NH Granite Advantage Health Care Program at 90% FMAP already, and where enrollment growth for NH has been the greatest both on a percentage (81.6%), and an absolute enrollment growth basis (41,924) since mid-March 2020. For Amendment #9 relative to the rates:

1. An end of year retroactive non-budget neutral rate adjustment based on actual enrollment was not actuarially made by the State's actuary, as the acuity impact is very likely de minimis.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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2. Rates are calibrated to reflect a PHE end date in April 2023. Once ended, beneficiaries whose eligibility determination shows they no longer meet eligibility criteria will be disenrolled from Medicaid as Federal guidance permits. In order to minimize gaps in healthcare coverage, DHHS, the MCOs, providers and other stakeholders are working to engage beneficiaries. The disenrollment activity is expected to reduce program membership and related costs over the course of the unwind enrollment period.
3. The rates per person aggregate modestly decrease, while the price limitation has increased to reflect the much higher than anticipated enrollment related to the PHE continuing. Generally, states anticipate that when the PHE disenrollment commences, the premiums will rise per person, but the number of people enrolled will decline. Over time, this will lead to lower contract price limitations due to declining enrollment. The enrollment decline and related cost-savings will be realized from exiting individuals who generally have lower illness burden and lower healthcare costs.
4. Tables 1A and 1B in the Appendix depict monthly capitation rates, by major population eligibility groups, and the percent change from the prior Amendment. The rates in Table 1A exclude directed payments which are fixed costs, while Table 1B includes the fixed costs. The price limitation change is calculated off of the Table 1B capitation rates. The rates in the aggregate decline favorably by 0.7% for standard and 2.4% for the GAHCP. Taken together, standard and GAHCP capitation rates decline favorably by 1.5%.
5. Table 2 lays out the capitation rate change components. The top half of the chart shows program changes that increased costs unfavorably by \$7.15 million. The two largest changes are related to legislation enacted into law in the recent legislative session to improve birthing services and ambulance rates. The third largest captures professional billing for Medicaid at state-owned psychiatric facilities. The bottom half of the chart reflects the actuarial rating adjustments that lowered costs by \$27.56 million. The three largest changes are an acuity adjustment, fixed costs that do not increase with the increase in enrollment, and staffed bed constraints in psychiatric capacity.

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lon A. Shabinette
Commissioner

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and the Honorable Council
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APPENDIX

Table 1A
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Excluding Directed Payments
April PHE End Date

Population	Amendment #8	Amendment #9	Rate Change
Standard Medicaid			
Base Population	\$348.04	\$348.81	-0.1%
CHIP	211.15	213.50	1.1%
Behavioral Health Population	1,459.07	1,431.84	-1.9%
Total Standard Medicaid	\$408.64	\$404.89	-0.4%
Granite Advantage Health Care Program			
Medically Frail	\$1,097.65	\$1,074.95	-2.1%
Non-Medically Frail	419.51	414.34	-1.2%
Behavioral Health Population	2,054.51	2,015.13	-1.9%
Total GAHCP	\$564.78	\$556.60	-1.5%
Grand Total	\$487.51	\$483.25	-0.9%

Table 1B
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Including Directed Payments
April PHE End Date

Population	Amendment #8	Amendment #9	Rate Change
Standard Medicaid			
Base Population	\$361.13	\$360.19	-0.3%
CHIP	216.61	218.32	0.8%
Behavioral Health Population	1,514.99	1,483.27	-2.1%
Total Standard Medicaid	\$420.82	\$418.10	-0.6%
Granite Advantage Health Care Program			
Medically Frail	\$1,150.89	\$1,113.50	-3.3%
Non-Medically Frail	432.57	423.65	-2.1%
Behavioral Health Population	2,097.00	2,050.34	-2.2%
Total GAHCP	\$583.49	\$570.08	-2.3%
Grand Total	\$483.43	\$478.60	-1.4%

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and the Honorable Council
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Table 2
New Hampshire Department of Health and Human Services
SFY 2023 MCO Capitated Rate Change by Component
Based on Projected SFY 2023 Enrollment by Rate Cell
April 2023 PUI: Bull Scenario

Rate Component	Standard Medical		CARCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Coverall Services and Fee Schedule Changes						
Remote patient monitoring services ¹	0.0%	44,502	0.0%	14,051	0.0%	68,553
Bathing services reimbursement ²	0.4%	2,704,803	0.0%	288,587	0.4%	2,993,390
Advanced lab tests ³	0.0%	181,054	0.0%	74,876	0.0%	255,930
Ambulance emergency medical transportation rates ⁴	0.1%	1,028,020	0.1%	973,491	0.1%	2,001,511
Friends and family NEMT rates ⁴	0.0%	905,170	0.1%	483,282	0.1%	1,388,452
Chair car transportation rates ⁴	0.0%	178,959	0.0%	111,769	0.0%	290,728
State-owned hospital professional services ⁴	0.1%	624,648	0.0%	182,778	0.1%	807,426
SUD residential services ⁴	0.0%	72,426	0.1%	646,173	0.0%	618,600
Total program changes	0.7%	5,139,692	0.4%	2,632,993	0.6%	7,772,685
Other changes relative to Amendment #8 SFY 2023 rating assumptions						
SFY 2023 policy adjustment compared to Amendment #8 acuity assumption ¹	-0.2%	(\$1,270,728)	-1.3%	(\$8,519,200)	-0.7%	(\$9,789,928)
October 2022 DRG weights ²	0.0%	158,231	0.0%	193,603	0.0%	351,834
State-owned hospital pricing constraints ³	-0.4%	(\$3,272,851)	-0.2%	(\$1,087,774)	-0.3%	(\$4,360,625)
Applied behavioral analysis service trends ³	-0.1%	(\$712,628)	0.0%	3,762	-0.1%	(\$708,866)
Impact of enrollment increase on the PMPM value of fixed-dollar directed payments ⁴	-0.5%	(\$3,973,112)	-1.1%	(\$7,346,323)	-0.8%	(\$11,319,435)
Other ⁴	-0.1%	(\$915,576)	-0.1%	(\$57,612)	-0.1%	(\$1,773,188)
Total other changes	-1.3%	(\$9,985,684)	-2.7%	(\$17,614,143)	-2.0%	(\$27,600,827)
Total rate change for Amendment #9 relative to Amendment #8 rates	-0.6%	(\$4,846,972)	-2.3%	(\$14,981,619)	-1.4%	(\$19,828,591)

1 The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.
 2 The other change component can include items, such as changes in fee-for-service fees from SFY 2022 to SFY 2023, base data updates, refreshed financial items from MCOs, and modifications to program change effective dates among other things.
 3 This change is retroactive to July 1, 2022. The fiscal impact represents a twelve-month period.
 4 This change is effective after July 1, 2022. The fiscal impact represents less than a twelve-month period.

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and the Honorable Council
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Medicaid Care Management Services Contract Amendment #9 Fiscal Details

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	\$575,768,481		\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	\$446,902,230	\$177,489,903	\$624,392,133
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
Sub-Total			\$1,864,849,263	\$177,489,903	\$2,042,339,166

05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION MEDICAID SERVICES, OFC OF MEDICAID SERVICES CHILD HEALTH INSURANCE PROGRAM

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,858,664		\$55,858,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$102,351,504		\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	\$102,152,951	\$16,223,840	\$118,376,791
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
Sub-Total			\$323,378,814	\$16,223,840	\$339,602,654

05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$618,433,737		\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	\$578,986,727	\$51,399,445	\$630,266,172
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
Sub-Total			\$2,285,487,609	\$51,399,445	\$2,336,887,054
Total Funds			\$4,473,716,686	\$245,113,188	\$4,718,829,874

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

Lori A. Shabinette
Commissioner

Henry D. Lipman
Director

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May 23, 2022

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$1,127,921,908 from \$3,345,793,778 to \$4,473,715,686, with no change to the completion date of August 31, 2024, and effective July 1, 2022, upon Governor and Council approval. All terms and conditions of the contract and prior amendment not inconsistent with this Amendment remain in full force and effect.

Funding sources are as follows:

	Federal	Other / Agency Income	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3.1)	0%
Child Health Insurance Program (CHIP)	66.1%	1.6%	32.3%
Standard Medicaid Population (Medicaid Care Management)	52.7%	22.2%	25.1%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of FMAP for the Children's Health Insurance Program (CHIP) population remains available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020

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(Item #6), January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), and as amended on December 08, 2021 (Item #6-1).

Funds are available in the accounts outlined in the attached fiscal details and are anticipated to be available in the State Fiscal Year (SFY) 2023, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

CMS requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2023.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request covers the rating period of July 1, 2022, through June 30, 2023. There are three key purposes for this amendment. They are:

1. Amendment #8 Target Medical Loss Ratio, Administrative Allowance, and Rates

- The Department's actuary projects an overall MCO medical loss ratio (MLR) for at-risk services of 90.8% for the Standard Medicaid population and 90.1% for the GAHCP population in SFY 2023, which includes the rate development highlights below.
 - An overall 7.7% administrative cost allowance for the Standard Medicaid population, and 8.4% for the GAHCP population; representing a reduction in percentages from SFY 2022 as funding remains consistent with the current contract period.
 - A 1.5% risk margin applied as a percentage of revenue prior to the directed payments and the 2.0% premium tax allowance.
 - The composite capitation rates shown are based on DHHS projections of MCO enrollment for SFY 2023, which include considerations for the unwind process following the end of the Public Health Emergency (PHE) with enrollment returning to near pre-PHE levels by March 2023. It is likely in the future Amendment #9 that enrollment will need to be recalibrated if the federal government continues to extend the federal PHE.
- Included in the Appendix to this letter:
 - Table 1A shows the rate impact excluding directed payments, as well as with and without the SMI/SED (Severely Mentally Ill/Severely Emotionally Disturbed) 1115 waiver amendment to the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) Demonstration at 3.8% to the total composite rate.

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and the Honorable Council
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- o Table 1B takes into account directed payments and reflects a change of 1.8%.
- o Table 2 shows the component changes leading to the 1.8% increase in composite rate.
- o The price limitation is \$168,631,814 less than SFY 2022 (prior to any legislation enacted after the contract date).

2. Risk Mitigation Structure

- Retrospective acuity adjustment due to the uncertainty surrounding the continuous membership unwind process following the end of the PHE as authorized by the Center for Medicare and Medicaid Services (CMS) Division of Managed Care Policy on May 11, 2022. The purpose is to appropriately account for this uncertainty; DHHS will implement a non-budget neutral retroactive acuity adjustment to include a preliminary acuity assumption that will be updated following the contract year to reflect the actual population covered throughout SFY 2023; the preliminary risk adjustment for the expected enrollment composition changes the amount to an \$11.9 million increase.

- Minimum and maximum medical loss ratio (MLR) remains in effect for SFY 2023, to protect against a windfall or underfunding of services within the Program.

The minimum MLR is set on a program-wide basis for each major population, such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs, the minimum MLR will be 88.3% for the Standard Medicaid population and 87.6% for the GAHCP population.

The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that MCOs will have a maximum loss of 2.0%. Based on the target MLRs the maximum MLR will be 94.3% for the Standard Medicaid population and 93.6% for the GAHCP population.

The final minimum and maximum MLRs for Standard Medicaid and GAHCP will be updated for the final retroactive acuity factor and any other changes implemented covering the amendment period starting January 2023.

- Other existing adjustment factors risk-neutral to the State continue in the Program. The risk mitigation structure is consistent with the structure included in the SFY 2022 capitation rates with the one modification to include a retrospective acuity adjustment that addresses uncertainty caused by the end of the PHE.
- On page 9 of the 2022-2023 Medicaid Managed Care Rate Development Guide, "CMS recommends all states implement a 2-sided risk mitigation strategy for rating periods impacted by the Public Health Emergency." Due to population and cost uncertainty related to the ongoing PHE and the anticipated enrollment redetermination process.

3. Other Program Rate Adjustments

- SFY 2023 component changes in Table 2 (see Appendix) are expressed relative to the same components in the SFY 2022 rates.
- Incorporation of the Institution for Mental Disease (IMD) SMI/SED Waiver effective July 1, 2022 (pending CMS approval), DHHS will implement its SMI/SED (Severely

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and the Honorable Council
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Mentally Ill/Severely Emotionally Disturbed) 1115 waiver amendment to the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) Demonstration.

The waiver amendment allows DHHS to claim additional federal matching funds for Medicaid enrollees aged 21 through 64 years treated in an Institution for Mental Disease (IMD), including at New Hampshire Hospital and Hampstead Hospital for lengths-of-stay greater than 15 days and no more than 60 days for an individual (the average length-of-stay for all beneficiaries cannot exceed 30 days).

- Medical trend adjustment since the start of the COVID-19 pandemic and PHE, service utilization levels in the Medicaid program have lagged behind CY 2019 utilization by rate cell and on an aggregate basis; therefore, capitation rates assume SFY 2023 utilization levels will be consistent with CY 2019. As such, utilization trends from CY 2019 to SFY 2023 remain constant with the exception of Applied Behavioral Analysis (ABA) services with an annual trend rate from CY 2019 to SFY 2023 at 21.7%. ABA services are an evidence-based consultation, assessment and treatment option for children with autism spectrum disorder or other developmental conditions that can improve social, communication, and learning skills.
- Preliminary acuity adjustment is an increase because it reduces costs by a lower amount in SFY 2023 than SFY 2022 largely due to the current estimate of enrollment timing and trajectory during the PHE unwind.
- Pharmacy trend and savings. The pharmacy trend assumptions in Table 2 are based on a combination of historical New Hampshire Medicaid data analysis, Milliman's research on utilization and cost trends, and publicly available trend reports and forecasts.

Pharmacy savings were shown in the preferred drug list (PDL) analysis. The pharmacy savings analysis undertaken for this amendment included savings related to adjustments for prescribing efficiency opportunities for several drug classes related to asthma, HIV, and autoimmune disorders. The savings amounted to \$907,740 for the rating period, though the savings were less than SFY 2022 resulting in a cost increase for this line item. Lastly, the J-code class of injectable drugs reflects market trends.

- Opioid addiction treatment trend adjustment to the base experience data underlying the MCM capitation rates to account for the estimated change in both prevalence and cost of treatment for the opioid addiction treatment population. Based on the Actuary's review of SFY 2015 through October 2021 MCO encounter data, they determined the proportion of opioid addiction population started to decrease for several rate cells. This decrease in the proportion of opioid addiction population results in adjustments of less than 1.00 for several rate cells.
- Directed payment adjustment to remove the completed SFY 2022 HCBS (Home and Community Based Service) payments related to time limited American Rescue Plan enhanced FMAP for HCBS.
- Funding for 14 additional Community Residential Beds coming into service. Expanded services to fund an additional 14-bed community residential services at roughly \$958,000 (including administration, premium tax and margin).

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and the Honorable Council
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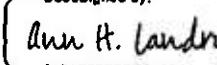
- Reimbursement adjustments to reflect recent or expected changes in the Medicaid Fee-for-Service (FFS) provider fee schedule based on Medicare Fee Schedule changes including:
 - Current Ambulatory Surgical Center fee schedule effective January 1, 2022;
 - Professional and other services fee schedules effective January 1, 2022; and
 - J-code repricing effective July 1, 2022, and other routine fee schedule updates.

- Other adjustments included in the rate change driver table (Table 2) for the SFY 2023 rates:
 - Base data update (e.g., lower/higher incurred but not reported (IBNR) expenses than previously estimated);
 - Enrollment projection impact on fixed dollar items (e.g., Community Mental Health Agreement funding);
 - Changes in FFS fee schedule from SFY 2022 to SFY 2023;
 - Refreshed financial data items from the MCOs (e.g., provider incentive payments);
 - Changes in enrollment information (e.g., retroactive change in rate cell assignment);
 - Changes in stop loss attachment point for high-cost member claims; and
 - Changes in program effective dates (e.g., Behavioral Health Crisis Treatment Centers (BHCTC), genetic testing)

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session. In the event the contract is not approved before June 30, 2022, the available federally permitted retroactive risk adjustment mitigation to account for the uncertainty of the PHE unwind will not be available to New Hampshire.

Respectfully submitted,

DocuSigned by:

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Lori A. Shabinette
Commissioner

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and the Honorable Council
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APPENDIX

Table 1A
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Excluding Directed Payments

Population	SFY 2022	SFY 2023		Percentage Change	
		Excluding Impact of SMI/SED 1115 Wavler Amendment	Total	Excluding Impact of SMI/SED 1115 Wavler Amendment	Total
Standard Medicaid					
Base Population	\$328.56	\$344.83	\$348.28	5.0%	5.4%
CHIP	192.68	213.87	214.07	10.9%	11.1%
Behavioral Health Population	1,381.53	1,408.40	1,461.70	1.9%	5.8%
Total Standard Medicaid	\$384.19	\$401.87	\$406.85	4.6%	5.9%
Granite Advantage Health Care Program					
Medically Frail	\$1,091.37	\$1,093.39	\$1,097.65	0.2%	0.6%
Non-Medically Frail	418.97	418.07	419.51	-0.2%	0.1%
Behavioral Health Population	1,933.60	1,951.04	2,033.28	0.9%	5.2%
Total GAHCP	\$563.17	\$563.42	\$568.33	0.0%	0.9%
Grand Total	\$441.88	\$453.94	\$458.90	2.7%	3.8%

Table 1B
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Including Directed Payments

Population	SFY 2022	SFY 2023		Percentage Change	
		Excluding Impact of SMI/SED 1115 Wavler Amendment	Total	Excluding Impact of SMI/SED 1115 Wavler Amendment	Total
Standard Medicaid					
Base Population	\$352.95	\$356.71	\$358.17	1.1%	1.5%
CHIP	198.39	219.27	219.67	10.5%	10.7%
Behavioral Health Population	1,470.78	1,464.33	1,517.68	-0.4%	3.2%
Total Standard Medicaid	\$410.57	\$416.00	\$420.98	1.3%	2.5%
Granite Advantage Health Care Program					
Medically Frail	\$1,144.47	\$1,146.77	\$1,150.99	0.2%	0.6%
Non-Medically Frail	432.79	431.13	432.57	-0.4%	-0.1%
Behavioral Health Population	2,001.29	1,992.81	2,075.12	-0.4%	3.7%
Total GAHCP	\$583.63	\$582.21	\$587.11	-0.2%	0.6%
Grand Total	\$466.35	\$469.57	\$474.53	0.7%	1.8%

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and the Honorable Council
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Table 2 New Hampshire Department of Health and Human Services SFY 2023 MCM Capitation Rate Change by Component Based on Projected SFY 2023 Enrollment by Rate Cell						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Inclusion of IMD admissions of less than 60 days for age 21-64 population as a covered Medicaid service through SMI/SED 1115 waiver amendment to the SUD-TRA 1115 demonstration						
Newly covered New Hampshire Hospital (NH) admissions repriced at NHH minimum fee schedule	1.1%	\$7,703,888	0.8%	\$3,755,578	1.0%	\$11,459,465
Reversal of IMD exclusion for other impacted services	0.1%	\$672,069	0.0%	\$163,043	0.1%	\$835,112
Total impact of SMI/SED 1115 waiver amendment	1.2%	\$8,375,957	0.8%	\$3,918,620	1.1%	\$12,294,578
Other program changes						
New Hampshire and Hampstead Hospitals – repricing to minimum fee schedule for services historically covered by MCM program	0.5%	\$3,450,993	0.1%	\$365,521	0.3%	\$3,816,514
Community residential services – additional beds	0.1%	745,993	0.0%	121,129	0.1%	867,123
Preliminary SFY 2023 acuity adjustment compared to SFY 2022 acuity assumption	0.7%	4,769,045	1.5%	7,211,955	1.0%	11,981,000
Total other program changes	1.3%	\$8,966,032	1.6%	\$7,698,605	1.4%	\$16,664,636
Other changes relative to SFY 2022 rating assumptions						
Non-pharmacy utilization trends	-1.1%	(7,844,706)	-1.1%	(5,248,839)	-1.1%	(13,093,545)
Opioid addiction treatment trend adjustment	-0.5%	(3,148,990)	-0.8%	(3,909,040)	-0.6%	(7,058,031)
Inpatient and outpatient hospital unit cost trends	0.5%	3,184,479	0.6%	2,980,746	0.5%	6,165,225
Applied behavioral analysis service trends	1.1%	7,450,186	0.0%	5,939	0.6%	7,456,105
Pharmacy trends	2.4%	16,751,556	0.3%	1,296,337	1.6%	18,047,893
Preferred drug list (PDL) adjustment	-0.1%	(1,000,190)	-0.9%	(4,038,173)	-0.4%	(5,036,363)
Pharmacy savings initiatives	0.0%	121,825	0.1%	406,868	0.0%	528,693
J Code fee schedule changes	0.1%	1,033,584	0.2%	991,855	0.2%	2,025,439
Boston Children's Hospital risk pool funding level	0.3%	1,955,549	0.0%	34,726	0.2%	1,990,275
Other	0.3%	2,227,495	0.0%	(21,256)	0.2%	2,206,240
Total Other Changes	3.0%	\$20,732,768	-1.6%	(\$7,498,837)	1.1%	\$13,233,931
Total rate change for SFY 2023 relative to SFY 2022 rates (prior to directed payment changes)	5.5%	\$38,074,756	0.9%	\$4,118,388	3.6%	\$42,193,145
Directed payment changes						
Removal of HCBS directed payment	-3.3%	(23,012,503)	-0.7%	(3,377,214)	-2.3%	(26,389,717)
Impact of enrollment decrease on the PMPM value of fixed-dollar directed payments ²	0.4%	2,431,500	0.4%	2,047,234	0.4%	4,478,733
Total directed payment changes	-3.0%	(\$20,581,003)	-0.3%	(\$1,329,981)	-1.9%	(\$21,910,984)
Total rate change for SFY 2023 relative to SFY 2022 rates (after directed payment changes)	2.5%	\$17,493,753	0.6%	\$2,788,408	1.8%	\$20,282,161

¹ The various rate change components include the impact of attributed administrative allowance, risk/profit margin, and premium tax beyond the service costs alone.

² The SFY 2023 directed payments remain at \$33 million for critical access hospitals and \$5 million for CMHCs. Lower projected enrollment for SFY 2023 compared to SFY 2022 results in higher PMPM amounts to fund the directed payments.

His Excellency, Governor Christopher T. Sununu,
and the Honorable Council
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Medicaid Care Management Services Contract Amendment #8 Fiscal Details

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND					
State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	\$575,768,481		\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	\$0	\$446,902,230	\$446,902,230
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,417,947,033	\$446,902,230	\$1,864,849,263
05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION MEDICAID SERVICES, OFC OF MEDICAID SERVICES CHILD HEALTH INSURANCE PROGRAM					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$102,351,504		\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	\$0	\$102,152,951	\$102,152,951
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$221,225,863	\$102,152,951	\$323,378,814
05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$618,433,737		\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	\$0	\$578,866,727	\$578,866,727
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,706,620,882	\$578,866,727	\$2,285,487,609
		Total Funds	\$3,345,793,778	\$1,127,921,908	\$4,473,715,686



Lori A. Shibinette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAID SERVICES

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December 2, 2021

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into **Retroactive** amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$107,893,151 from \$3,237,900,627 to \$3,345,793,778, with no change to the completion date of August 31, 2024, and effective retroactive to July 1, 2021 upon Governor and Council approval. Funding sources are as follows:

	Federal	Other	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	67.40%	0%	32.60%
Standard Medicaid Population (Medicaid Care Management)	53.57%	0%	46.43%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of FMAP for the Children's Health Insurance Program (CHIP) population remains available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. Additionally, the American Rescue Plan of 2021 potentially provides an additional 10% FMAP for a one year period (April 1, 2021-March 31, 2022) for certain home and community based services (HCBS) covered in this contract based on an approved Centers for Medicare and Medicaid Services (CMS) HCBS spending plan. The Department will request Fiscal Committee approval to accept and expend additional amounts for January 2022 forward. The adjusted price limitation, given the enhanced FMAP and provisions in HB 2, should be sufficient to stay within the budget for SFY 2022. Legislation under consideration by Congress could impact the CHIP and Standard Federal share amounts.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020

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and the Honorable Council
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(Item #6), January 22, 2021 (Item #9), and as amended on June 30, 2021 (Item # Tabled Item 8A).

Funds are available in the accounts outlined in the attached fiscal details and are anticipated to be available in the State Fiscal Year (SFY)2022, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

CMS requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2022.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request is **Retroactive** because it covers the rating period of July 1, 2021, through June 30, 2022. There are three key purposes for this amendment:

- First, is to incorporate the impact of acuity (i.e., the measure of beneficiaries' collective medical conditions) due to an increase in new enrollment as the result of an extended federal public health emergency and extended continuous enrollment. Generally, there has been a decrease in acuity that moderates claims expense costs compared to the rates approved under Amendment #6;
- Second, is to incorporate the increased costs of legislative changes from both federal legislation and state actions in the most recent legislative session; and
- Third, is to incorporate fee schedule updates, and an adjustment for pharmacy management.

Further Explanation

Amendment #7 adjusts the SFY 2022 capitation rates. The Department's contracted actuary, Milliman, projects an overall MCO medical loss ratio (MLR) for at-risk services of 90.7% for the Standard Medicaid population and 90.0% for the GAHCP population in SFY 2022, which includes the rate development highlights below.

Milliman used the following methodology to develop the New Hampshire MCM program capitation rates:

1. Rate methodology

The methodology used to develop the Amendment #7 SFY 2022 MCM capitation rates is consistent with the Amendment #6 capitation rate methodology.

2. Changes in enrollment

CMS instructed the Department to review emerging enrollment and Public Health Emergency (PHE) conditions for Amendment #7. The updated capitation rates are based

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and the Honorable Council
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on the Department's updated projections of MCO enrollment for SFY 2022 which include continued enrollment growth through SFY 2022.

3. Acuity adjustment

For the Amendment #7 SFY 2022 MCM capitation rates, Milliman updated the acuity adjustment factors taking into account the nature of the new enrollment compared to historical enrolled individuals.

4. Federal and State Legislative actions

a. Home and community based services (HCBS) enhanced federal funding
HCBS directed payments available under Section 9817 of the American Rescue Plan Act (ARPA) provide enhanced federal funding for state Medicaid spending on home and community based services. Beginning April 1, 2021, through March 31, 2022, states are eligible to receive a ten (10) percentage point increase in their FMAP for specified HCBS services. In order to claim the enhanced FMAP eligible under the MCO contracts, the Department is proposing to implement a new directed payment initiative estimated at \$28 million for certain eligible HCBS state plan services (pending CMS approval). Rates for directed payments do not include an additional allowance for administrative expense or risk margin for this addition. The directed payment is subject to premium tax.

b. State Legislative benefit updates

i. Home visiting services for pregnant women and infants ages 0-1 year consistent with HB 2 beginning October 1, 2021, were prorated 9-months at estimated annual costs of \$1.853 million.

ii. Genetic testing reimbursement for hospitals in accordance with HB 600.

5. Fee schedule updates, include:

a. DRG inpatient hospital unit cost trend updates using the actual 2022 DRG weights effective October 1, 2021. A review of the newly released weights suggests a 0.0% unit cost trend between 2021 and 2022 compared to the Amendment #6 assumption of a 0.56% increase based on historical data.

b. Neuro-psychiatric testing codes within the Calendar Year 2021 fee schedule included a number of incorrect entries for several neuro-psychiatric testing codes which prompted an update to reimbursement adjustment factors. The estimated impact of the correction is an increase of approximately \$135,000 for SFY 2022.

c. Other fee schedule changes, include:

i. Unit cost adjustment for latex gloves and a fee schedule update for vaccine administration account for an additional \$310,000 in SFY 2022.

ii. New durable medical equipment (DME) and supplies (breast milk storage bags, peristeen pumps) with annual costs estimated at \$280,200 and \$135,000, respectively (effective October 1, 2021).

iii. Behavioral health crisis treatment center program services transferring to the State's redesigned Mobile Crisis Response Program.

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- iv. Preferred drug list (PDL) updates to include different formulations of drugs already included on the PDL.
- v. Community residential services beds service projection updates.

6. Prescription drug savings adjustments

An adjustment to rates is included to account for differences in MCO pharmacy management (e.g., adherence to generally accepted quantity limits for three (3) therapeutic classes, opioid prescribing patterns, prior authorization denial rates) with annual savings of \$1.59 million incorporated into the rates.

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session. In the event the contract is not approved, available federal relief to HCBS providers and their direct care workers would not be available.

Respectfully submitted,



Lori A. Shibinette
Commissioner

Medicaid Care Management Services Contract Amendment #7 Fiscal Details

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND					
State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	\$478,176,246	\$97,592,235	\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,320,354,798	\$97,592,235	\$1,417,947,033
05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$105,226,028	(\$2,874,524)	\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$224,100,386	(\$2,874,524)	\$221,225,863
05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$605,258,297	\$13,175,440	\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,693,445,442	\$13,175,440	\$1,706,620,882
		<i>Amendment #7</i>	Current Budget	Increase / (Decrease)	Revised Budget
		Total Funds	\$3,237,900,627	\$107,893,151	\$3,345,793,778

**Medicaid Care Management Services Contract
Amendment #7 Fiscal Details**

Table 1A
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2022 Capitation Rate Change
Based on Projected SFY 2022 Enrollment by Rate Cell
Excluding Directed Payments

Population	Amendment #6 SFY 2022	Amendment #7 SFY 2022	Percentage Change
	Capitation Rate (assuming PHE ends in December 2021)	Capitation Rate	
	Standard Medicaid		
Base Population	\$333.44	\$329.75	-1.1%
CHIP	198.87	196.50	-1.2%
Behavioral Health Population	1,362.27	1,369.33	0.5%
Total Standard Medicaid	\$393.22	\$390.53	-0.7%
	Granite Advantage Health Care Program		
Medically Frail	\$1,102.60	\$1,091.37	-1.0%
Non-Medically Frail	434.71	418.97	-3.6%
Behavioral Health Population	1,924.66	1,937.48	0.7%
Total GAHCP	\$584.51	\$569.64	-2.5%
Grand Total	\$462.92	\$455.79	-1.5%

Table 1B
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2022 Capitation Rate Change
Based on Projected SFY 2022 Enrollment by Rate Cell
Including Directed Payments

Population	Amendment #6 SFY 2022	Amendment #7 SFY 2022	Percentage Change
	Capitation Rate (assuming the PHE ends in December 2021)	Capitation Rate	
	Standard Medicaid		
Base Population	\$344.61	\$354.31	2.8%
CHIP	204.22	202.50	-0.8%
Behavioral Health Population	1,413.46	1,457.38	3.1%
Total Standard Medicaid	\$406.64	\$417.37	2.6%
	Granite Advantage Health Care Program		
Medically Frail	\$1,154.24	\$1,144.47	-0.8%
Non-Medically Frail	449.47	432.79	-3.7%
Behavioral Health Population	1,960.95	2,005.23	2.3%
Total GAHCP	\$604.49	\$590.37	-2.3%
Grand Total	\$478.73	\$480.41	0.3%

**Medicaid Care Management Services Contract
Amendment #7 Fiscal Details**

Table 2 New Hampshire Department of Health and Human Services Amendment #6 vs. Amendment #7 SFY 2022 MCM Capitation Rate Change by Component¹ Based on Projected SFY 2022 Enrollment by Rate Cell						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Program Changes						
Benefit Updates	0.2%	\$1,760,394	0.0%	\$114,928	0.1%	\$1,875,322
Allowance for Genetic Testing for Hospitals per HB 600	0.0%	120,592	0.0%	-	0.0%	120,592
Behavioral Health Crisis Treatment Center Update	0.0%	(28,652)	0.0%	(87,990)	0.0%	(116,642)
Home and Community Based Services Directed Payment (TBD)	3.4%	24,176,318	0.7%	4,334,931	2.2%	28,511,250
Total Program Changes	3.7%	\$26,028,652	0.7%	\$4,361,870	2.3%	\$30,390,522
Other Changes Relative to Amendment #6 Rating Assumptions						
Fee Schedule and DRG Trend Updates	0.0%	\$136,594	0.0%	(\$163,400)	0.0%	(\$26,805)
Update to Community Residential Services Bed Projections	0.0%	38,651	0.0%	6,452	0.0%	45,104
PDL Update	0.0%	128,414	0.0%	(74,195)	0.0%	54,219
Acuity Adjustment Update	-0.7%	(4,885,580)	-1.8%	(11,050,153)	-1.2%	(15,935,733)
Prescription Drug Savings	-0.1%	(974,522)	-0.2%	(1,165,118)	-0.2%	(2,139,640)
PMPM Impact of Updated Enrollment Projections on Fixed Dollar Rate Components	-0.3%	(1,826,101)	-1.0%	(5,986,171)	-0.6%	(7,812,272)
Total Other Changes	-1.0%	(\$7,382,543)	-3.1%	(\$18,432,585)	-2.0%	(\$25,815,127)
Total Rate Change for SFY 2022 Relative to Amendment #6 Rates	2.6%	\$18,646,109	-2.3%	(\$14,070,715)	0.3%	\$4,575,394

¹The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAID SERVICES

Lori A. Shabinette
Commissioner

Henry D. Lipman
Director

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May 27, 2021

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total shared price limitation by \$1,188,660,571 from \$2,049,240,056 to \$3,237,900,627, with no change to the completion date of August 31, 2024 effective July 1, 2021 or upon Governor and Council approval, whichever is later. Funding sources are as follows:

	Federal	Other	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	71.88%	0.50%	27.62%
Standard Medicaid Population (Medicaid Care Management Account)	53.12%	22.56%	24.32%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of federal medical assistance percentage (FMAP) for the CHIP population could become available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. Additionally, the American Rescue Plan of 2021 potentially provides an additional 10% FMAP for a one year period (April 1, 2021-March 31, 2022) for certain home and community based services covered in this contract based on approved Centers for Medicare and Medicaid Services (CMS) spending plan, which is subject to further federal guidance at this juncture. If the additional funding is received the Department will request Fiscal Committee authority to accept, and expend additional amounts for January 2022 forward.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020 (Item #6), and January 22, 2021 (Item #9).

Funds are available in the accounts outlined in the attached fiscal details for State Fiscal Year (SFY) 2021, and are anticipated to be available in the SFYs 2022 through 2023 with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

CMS requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2023.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes and legislatively approved rate increases are included as well.

EXPLANATION

This request covers the rating period of July 1, 2021 through June 30, 2022.

Summary of Key Changes

Exhibit A. Program Change Summary:

1. A carry forward of staffing requirements from amendment #5
2. Added provision that Members shall not be required to change covered prescription drugs more than once per calendar year, with limited exceptions.
3. Further extension of additional preferential auto-assignment awards for high-performing MCO(s) consistent with Alvarez & Marsal's report recommendation incorporated initially the last MCO contract amendment.
4. New CMS Managed Care Rule provisions effective July 1, 2021 concerning beneficiary/member rights.
5. Update to the National Committee for Quality Assurance (NCQA) reporting compliance requirements.
6. New Directed Payment for Community Residential Services provided by Community Mental Health Centers (CMHCs) and Psychiatric Designated Receiving Facilities (DRFs); continuation of Directed Payments for Durable Medical Equipment (DME), CMHCs, and Critical Access Hospitals (CAHs).
7. The inclusion of CMS requested language for historical directed payments terms.
8. Elimination of risk corridor and replacement with Minimum and Maximum Medical Loss Ratios (MLRs), the effect of which reduces the state's risk compared to the SFY 2020 and 2021 Risk Corridors. The state has greater enrollment risk due to the unpredictable length of the federal public health emergency.

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9. The minimum MLR is set at 88.2% for the Standard Medicaid population and 87.4% for the Granite Advantage Health Care Program (GAHCP) population. The maximum MLR shall be 94.2% for the Standard Medicaid population and 93.4% for the GAHCP population.

10. Any incentive payments made to higher-performing MCOs as part of the Withhold and Incentive Program shall not impact the minimum or maximum MLR provision of the contract.

11. For the period July 1, 2021 through June 30, 2022 rating period, MCOs will receive a one-time kick payment for each Member psychiatric admission stay with DRG code 880-887 subject to limited exceptions.

12. Sets the MCO administrative allowance for SFY 2022 at the 40th percentile, or \$35.78 PMPM (Per Member Per Month) SFY 21 had a blended administrative allowance of \$37.00 PMPM.

The state's actuary Milliman used the following methodology to develop the New Hampshire MCM program capitation rates:

1. Summarize CY 2018 and CY 2019 MCO encounter experience data for the Standard Medicaid and GAHCP Medically Frail eligible population and the March 2019 to December 2019 MCO encounter data for the GAHCP Non-Medically Frail population.
2. Project estimated statewide SFY 2022 MCM program medical costs for all covered services by rate cell.
3. Blend the projected SFY 2022 costs based on CY 2018 and CY 2019 encounter data.
4. Adjust SFY 2022 projected medical costs for all rate cells for benefits not included in the base experience data, expected administrative expenses, margin, and premium tax.

Medicaid enrollment is projected to remain elevated through the end of the federal Department of Health and Human Services declared PHE. There still exists uncertainty related to the end of the PHE. As such, Milliman prepared two (2) separate enrollment scenarios: 1) the PHE ends December 2021, and 2) the PHE ends September 2021:

- Each scenario assumes enrollment returning to pre-COVID levels due to the reinstatement of eligibility redetermination activities three (3) months following the end of the PHE.
- The changes in enrollment are anticipated to impact the average acuity of beneficiaries. For rate cells modeled to have significant enrollment differences due to the PHE; newer enrollees having lower illness burden, the rate development includes an acuity adjustment for each scenario.
- The Department will initially pay capitation rates based on the December 2021 scenario, but will retroactively pay capitation rates under the September 2021 scenario if the PHE ends prior to October 1, 2021.

The capitation rates do not include provisions for expected vaccination administration fees related to COVID-19 in SFY 2022. The cost of vaccination administration fees remain carved out of the MCM program. Based on the interplay of other funding sources. The SFY 2022 capitation rates do not include any explicit adjustments for the following:

- COVID-19 Testing and Treatment Cost: The prevalence of COVID-19 infection rates in SFY 2022 is dependent on many variables that make it difficult to predict to include an

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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estimate for the cost of testing for and treating individuals with COVID-19 including, but not limited to:

- The take-up rate and timing of COVID-19 vaccinations;
- The emergence of COVID-19 variants and the efficacy of vaccines on these variants; and
- The implementation of social distancing measures.

Milliman advises, there is not a publicly available model that includes COVID-19 infection rate or hospital admissions through June 2022. In addition, the publicly available models have materially changed short-term and long-term projections of COVID-19 prevalence in reaction to emerging data. While Milliman reviewed historical MCM data for the cost of testing and treating COVID-19 in CY 2020, given the unpredictable patterns of COVID-19 prevalence to date in New Hampshire and the changing national models there is a range of potential impacts on the SFY 2022 rates.

The most significant fiscal impact of COVID-19 to date has been the deferral of non-essential services, either through government-enacted policies, the impact of social distancing on the administration of services, or personal choice. Milliman reviewed MCM emerging claims data incurred through February 2021 by population type (to remove the impact of membership mix changes). As of February 2021, there was still measurable reductions in claim costs for each population compared to the PMPMs prior to the pandemic in CY 2019. However, Milliman advises it is difficult to use this historical data to project the impact of deferred services for SFY 2022 for many reasons.

- Utilization by service category has varied in CY 2020 and early CY 2021 as the level of COVID-19 diagnoses and hospital admissions has changed in New Hampshire over the course of the pandemic. Therefore, the unknown future prevalence of COVID-19 will be a key variable in future service utilization changes relative to pre-pandemic levels.
- Limited data is available to understand how beneficiary behavior will change during and after the roll-out of the COVID-19 vaccination. As such, there could still be a wide range of possibilities as to when service utilization may return to pre-pandemic levels or if there will be increased utilization due to pent up demand.
- In the MCM data Milliman reviewed it is difficult to isolate the impact of deferred services from changes in utilization due to other drivers, such as member acuity changes or change in service mix.


His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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In response to the pandemic, the mix of services used to treat patients has changed, such as the use of telehealth services. It is unknown if these provider and patient changes will persist after the end of the pandemic.

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP necessary to cover the program are not sufficient, the projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shibinette
Commissioner

Medicaid Care Management Services Contract Amendment #6 Fiscal Details

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	TBD	\$478,176,246	\$478,176,246
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$842,178,552	\$478,176,246	\$1,320,354,798

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	TBD	\$105,226,028	\$105,226,028
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$118,874,358	\$105,226,028	\$224,100,386

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	TBD	\$605,258,297	\$605,258,297
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$1,088,187,145	\$605,258,297	\$1,693,445,442
Grand Total			\$2,049,240,056	\$1,188,660,571	\$3,237,900,627

**Medicaid Care Management Services Contract
Amendment #6 Fiscal Details**

Table 1A			
New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Excluding Directed Payments – PHE Ending December 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$323.46	\$334.52	3.4%
CHIP	183.38	196.79	7.3%
Behavioral Health Population	1,398.23	1,362.47	-2.6%
Total Standard Medicaid	\$387.45	\$395.22	2.0%
Restated Total Standard Medicaid¹	\$387.45	\$398.48	2.8%
Granite Advantage Health Care Program			
Medically Frail	\$1,201.72	\$1,102.08	-8.3%
Non-Medically Frail	456.03	434.66	-4.7%
Behavioral Health Population	1,966.46	1,883.55	-4.2%
Total GAHCP	\$604.71	\$577.79	-4.5%
Restated Total GAHCP¹	\$604.71	\$578.69	-4.3%
Grand Total	\$457.62	\$454.19	-0.8%
Restated Grand Total¹	\$457.62	\$456.68	-0.2%

¹ Removes community residential service costs from January 2021 to June 2021 capitation rates to allow for a consistent comparison since those service costs will move into a directed payment for SFY 2022.

Table 1B			
New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Excluding Directed Payments – PHE Ending September 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$321.40	\$334.56	4.1%
CHIP	182.99	197.56	8.0%
Behavioral Health Population	1,376.46	1,361.95	-1.1%
Total Standard Medicaid	\$379.07	\$390.43	3.0%
Restated Total Standard Medicaid¹	\$379.07	\$393.77	3.9%
Granite Advantage Health Care Program			
Medically Frail	\$1,201.72	\$1,124.54	-6.4%
Non-Medically Frail	456.03	442.13	-3.0%
Behavioral Health Population	1,966.55	1,923.25	-2.2%
Total GAHCP	\$606.10	\$589.77	-2.7%
Restated Total GAHCP¹	\$606.10	\$590.79	-2.5%
Grand Total	\$448.95	\$451.79	0.6%
Restated Grand Total¹	\$448.95	\$454.42	1.2%

¹ Removes community residential service costs from January 2021 to June 2021 capitation rates to allow for a consistent comparison since those service costs will move into a directed payment for SFY 2022.

**Medicaid Care Management Services Contract
Amendment #6 Fiscal Details**

Table 1C New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Including Directed Payments – PHE Ending December 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$334.19	\$345.73	3.5%
CHIP	188.46	202.02	7.2%
Behavioral Health Population	1,447.43	1,455.31	0.5%
Total Standard Medicaid	\$400.38	\$411.91	2.9%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.31	\$1,154.24	-6.6%
Non-Medically Frail	474.37	449.47	-5.2%
Behavioral Health Population	2,004.30	1,937.80	-3.3%
Total GAHCP	\$625.70	\$598.45	-4.4%
Grand Total	\$473.15	\$472.16	-0.2%

Table 1D New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Including Directed Payments – PHE Ending September 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$332.13	\$346.06	4.2%
CHIP	188.05	202.92	7.9%
Behavioral Health Population	1,426.26	1,463.18	2.6%
Total Standard Medicaid	\$391.87	407.59	4.0%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.31	\$1,181.62	-4.4%
Non-Medically Frail	474.37	458.53	-3.3%
Behavioral Health Population	2,004.39	1,985.83	-0.9%
Total GAHCP	\$627.10	\$612.72	-2.3%
Grand Total	\$464.27	\$470.73	1.4%

**Medicaid Care Management Services Contract
Amendment #6 Fiscal Details**

Table 2 New Hampshire Department of Health and Human Services SFY 2022 MCM Capitation Rate Change by Component ¹ Based on Projected SFY 2022 Enrollment by Rate Cell PHE Ending in December 2021						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Program Changes						
MCRT / ES Services Carve Out	-0.4%	(\$2,511,022)	-0.3%	(\$1,340,348)	-0.3%	(\$3,851,370)
Change to Hospital Directed Payment ²	-0.1%	(399,878)	-0.1%	(354,365)	-0.1%	(754,243)
Increase to Community Residential Services Reimbursement Incorporated into New Directed Payment	0.3%	1,810,745	0.0%	174,077	0.2%	1,984,822
Total Program Changes	-0.2%	(\$1,100,155)	-0.3%	(\$1,520,636)	-0.2%	(\$2,620,791)
Other Changes Relative to January 2021 to June 2021 Rating Assumptions						
Administrative Allowance Increase	0.9%	\$6,083,179	0.9%	\$4,693,554	0.9%	\$10,776,732
Acuity Adjustment Related to Increased MCM Program Enrollment	-1.0%	(7,125,086)	-1.3%	(6,712,787)	-1.2%	(13,837,873)
Change to Boston Children's Hospital Funding	0.0%	102,338	0.0%	6,968	0.0%	109,306
Change to PDL Adjustment Assumptions	0.6%	4,011,893	0.3%	1,502,964	0.5%	5,514,857
Change to Prescription Drug Trend Assumptions	-1.0%	(7,104,913)	-2.1%	(10,731,192)	-1.5%	(17,836,105)
Change to Outpatient Reimbursement Trend Assumptions	0.6%	4,100,658	0.7%	3,320,370	0.6%	7,421,028
Removal of SFY 2021 COVID-19 Adjustment	2.8%	19,122,578	-0.6%	(2,883,904)	1.4%	16,238,674
Impact of MCO PBM Change	-0.4%	(2,622,185)	-0.5%	(2,876,315)	-0.4%	(5,298,501)
Minimum DME Fee Schedule Evaluation Approach	-0.8%	(5,684,056)	-0.6%	(2,958,499)	-0.7%	(8,642,555)
Base Data Change and Other	1.4%	9,840,615	-0.8%	(4,162,099)	0.5%	5,678,515
Total Other Changes	3.0%	\$20,725,018	-4.1%	(\$20,600,940)	0.0%	\$124,078
Total Rate Change for SFY 2022 Relative to January 2021 to June 2021 Rates	2.9%	\$19,624,863	-4.4%	(\$22,121,576)	-0.2%	(\$2,496,713)

¹ The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.

² The change in hospital directed payment represents the incremental change from the \$33.7 million included in the SFY 2021 capitation rates. The total hospital directed payment is \$33 million for SFY 2022.



Lori A. Shibinette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

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December 30, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into **Retroactive** amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by decreasing the total shared price limitation by \$128,374,314 from \$2,177,614,370 to \$2,049,240,056, with no change to the completion date of August 31, 2024 effective retroactive to July 1, 2020 upon Governor and Council approval.

Funds for Granite Advantage Health Program (GAHCP) are 90% Federal and 10% Other (as defined in RSA 126-AA:3, 1); funds for the Child Health Insurance Program are 74.23% Federal and 25.77% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 52.5% Federal, 24.15% General and 23.35% Other funds. An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population could become available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. If the forgoing materialize, DHHS would go to the Fiscal Committee to increase, accept, and expend amounts for January 2021 forward.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), and most recently amended with Governor and Council approval on June 10, 2020 (Item #6).

Funds are available in the accounts outlined in the financial section for State Fiscal Year 2021, and are anticipated to be available in the State Fiscal Years 2022 through 2025, with authority to adjust amounts within the price limitation between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for State Fiscal Years 2020-2021.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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See attached fiscal details.

EXPLANATION

This request is **Retroactive** because this Amendment covers the retrospective rating period July 1, 2020 through June 30, 2021. The State negotiated in the original SFY2021 rates the opportunity to refresh actuarial estimates. The State was able to use this added flexibility from CMS due to the Public Health Emergency, uncertainties related to COVID-19 treatment and costs, and utilization impact on non-COVID services. The most material initial actuarial estimate was for the costs of deferred care from the prior contract period. As the Public Health Emergency has continued this became a key assumption to revisit as has the enrollment and the composition thereof.

Fiscal table budget amounts reflect more current utilization and enrollment experience, enhanced FMAP available and accepted thus far. Adjustments to administrative costs, program changes and legislatively approved rate increases are included as well.

CMS published a new Medicaid Managed Care rule in November 2020 with provisions effective either December 14, 2020 or July 1, 2021. Those provisions taking effect in December 2020 are incorporated herein and are procedural rather than economic in impact to this Agreement.

Summary of Key Changes

The reduction in price limitation reflects a slightly less steep enrollment growth based on the State of New Hampshire's employment recovery with a greater than expected length of the PHE and maintenance of effort required to earn the enhanced FMAP. DHHS had forecast average monthly enrollment for the contract year of just over 215,000 people, whereas based on experience DHHS now forecast about 208,000 people. This reduction along with a 3% reduction globally in the capitation rates to be paid to the MCOs accounts for the favorable price limitation change.

The 3% capitation rate reduction is a function of net changes, totaling \$38,077,712. The single largest favorable change is related to more favorable COVID-19 cost experience of \$30,774,811. Rather than a 1.2% increase in this SFY 21 period for care deferred care before June 30, 2020, the adjustment for the full twelve month period is a 1.3% decrease.

The second largest favorable adjustment is for MCO administrative costs of \$17,406,265 (or 2.5% of capitation excluding directed payments and premium tax) for the period of January through June, 2021. This reduction reflects an analysis of what the PHE has permitted the MCOs to implement under the contract, what is likely to be able to be advanced in this period given an extension of the PHE due to waves of COVID-19 surge as well as recalibration of those activities where the return on investment looks longer than anticipated back when the contract was developed.

These and other administrative allowance adjustments represent an adjusted administrative allowance consistent with the 50th percentile for the full period (previously, the 75th percentile) and the 32nd percentile for the last six months. Administrative cost benchmarks of other Medicaid managed care plans and within the MCM program were assessed by the state's actuaries.

Offsetting these two key favorable cost adjustments are increases related to the HB4 3.1% provider rate increase amounting to \$13,775,736 for the period January through June 2021 and an increase in the Boston Children's Hospital risk pool of \$4,847,238 for the full twelve month period

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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reflecting more recent reported experience, other changes can be seen in Table A. The resulting composite capitation rates can be seen in Table B; the net is a 3% reduction.

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 90% Federal and 10% Other; funds for the Child Health Insurance Program are 74.23% federal as appropriated by Congress and 25.77% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 52.50% Federal as appropriated by Congress, 24.15% General and 23.35% Other funds.

In the event that the non-federal Other funds for the GAHCP necessary to cover the program are not sufficient, the projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shibinette
Commissioner

**Medicaid Care Management Services Contract
Amendment #5 Fiscal Details**

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$598,415,047	(\$64,904,641)	\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$907,083,193	(\$64,094,641)	\$842,178,552

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$70,490,459	(\$7,484,764)	\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$126,359,123	(\$7,484,764)	\$118,874,358

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$692,143,775	(\$55,984,909)	\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$1,144,172,054	(\$55,984,909)	\$1,088,187,145
Grand Total			\$2,177,614,370	(\$128,374,314)	\$2,049,240,056

**Medicaid Care Management Services Contract
Amendment #5 Fiscal Details**

Table A New Hampshire Department of Health and Human Services SFY 2021 MCM Capitation Rate Change by Component¹ Based on Projected SFY 2021 Enrollment by Rate Cell						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Program Changes						
2021 DRG fee schedule	0.0%	(\$247,823)	0.0%	(\$251,060)	0.0%	(\$498,883)
Stop loss attachment point indexing	0.0%	265,222	0.0%	-	0.0%	265,222
Removal of MCO psychiatric consult service	0.0%	(181,666)	0.0%	(128,796)	0.0%	(310,462)
Administrative allowance changes related to MCM contract restructuring and benchmarking	-1.3%	(9,169,440)	-1.5%	(8,236,825)	-1.4%	(17,406,265)
House Bill 4 3.1% provider rate increase	1.1%	7,860,466	1.1%	5,915,270	1.1%	13,775,736
Updated DME fee schedule	0.0%	99,383	0.0%	14,580	0.0%	113,962
Fee schedule changes related to Medicare	0.0%	(218,541)	0.0%	(211,407)	0.0%	(429,947)
Total Program Changes	-0.2%	(\$1,592,398)	-0.5%	(\$2,898,238)	-0.4%	(\$4,490,636)
Other Changes						
COVID adjustment impact	-3.8%	(\$26,877,600)	-0.7%	(\$3,897,211)	-2.5%	(\$30,774,811)
Increase to BCH risk pool	0.7%	4,782,251	0.0%	64,987	0.4%	4,847,238
Behavioral Health Crisis Treatment Center utilization adjustment	0.0%	(160,346)	0.0%	(20,322)	0.0%	(180,669)
PMPM recalibration of fixed dollar rate components	-0.1%	(464,544)	-0.1%	(416,071)	-0.1%	(880,615)
Enhanced TPL recoveries and cost avoidance activities	-0.1%	(881,248)	-0.1%	(705,194)	-0.1%	(1,586,442)
Enhanced PDL compliance	0.0%	(75,548)	0.0%	(83,591)	0.0%	(159,139)
Voluntary Psychiatric Admissions	0.1%	377,733	0.3%	1,542,363	0.2%	1,920,097
Base data change and other	-0.1%	(868,319)	-1.1%	(5,904,416)	-0.5%	(6,772,736)
Total Other Changes	-3.4%	(\$24,167,621)	-1.7%	(\$9,419,455)	-2.7%	(\$33,587,076)
Total Rate Change for SFY 2021 Relative to Original SFY 2021 Rates	-3.7%	(\$25,760,019)	-2.2%	(\$12,317,693)	-3.0%	(\$38,077,712)

¹ The various rate change components include the impact of attributed administrative allowance, risk / profit margin and premium tax beyond the service costs alone.

Medicaid Care Management Services Contract Amendment #5 Fiscal Details

Table B New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2021 Capitation Rate Change Based on Projected SFY 2021 Enrollment by Rate Cell¹					
Population	Original SFY 2021 Capitation Rate Adjusted for Enrollment Mix	Updated July 2020 to Dec 2020 Capitation Rate	Updated Jan 2021 to June 2021 Capitation Rate	Updated SFY 2021 Capitation Rate ²	Percentage Change from Original SFY 2021 Rate
Standard Medicaid					
Base Population	\$350.81	\$336.50	\$336.84	\$336.68	-4.0%
CHIP	198.67	193.77	187.23	190.30	-4.2%
Behavioral Health Population	1,460.51	1,401.17	1,442.01	1,422.21	-2.6%
Total Standard Medicaid	\$418.14	\$402.24	\$403.36	\$402.82	-3.7%
Granite Advantage Health Care Program					
Medically Frail	\$1,273.88	\$1,246.34	\$1,236.31	\$1,241.25	-2.6%
Non-Medically Frail	486.18	481.16	474.37	477.49	-1.8%
Behavioral Health Population	2,086.30	2,097.98	1,996.27	2,010.49	-3.6%
Total GAHCP	\$664.64	\$655.36	\$644.82	\$649.69	-2.2%
Grand Total	\$499.20	\$483.07	\$484.85	\$484.00	-3.0%

¹ Projected enrollment reflects DHHS estimates provided on December 9, 2020, with 1,193,381 member months for July 2020 to December 2020 and 1,312,169 member months for January 2021 to June 2021.

² The updated SFY 2021 capitation rates are a blend of the July 2020 to December 2020 rates and the January 2021 to June 2021 rates based on projected member months by rate cell.

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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Lori A. Shibinette
Commissioner

Henry D. Lipman
Director

May 26, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to retroactively amend existing agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schraff's City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM). and by increasing the shared price limitation by \$1,361,049,281 from \$816,565,089 to an amount not to exceed \$2,177,614,370, with no change to the completion date of August 31, 2024, effective upon Governor and Executive Council approval.

Funds for Granite Advantage Health Program (GAHCP) are 90% Federal and 10% Other (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 67.88% Federal and 32.12% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51.01% Federal, 22.56% General and 26.43% Other funds. An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population could become available if the public health emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. The funding percentage of the Child Health Insurance Program (CHIP) is already subject to enhancement through September 2020; the CARES Act would enhance that to 80.84% if the PHE continues into the first quarter of State Fiscal Year 2021. If the forgoing materialize, DHHS would go to the Fiscal Committee to increase, accept, and expend amounts.

This agreement was originally approved by the Governor and Executive Council on March 27, 2019 (Tabled Late Item A), and subsequently amended on April 17, 2019 (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A).

Funds are available in the following accounts for State Fiscal Year 2021, and are anticipated to be available in the State Fiscal Years 2022 through 2025, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office; if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for State Fiscal Year 2021.

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	TBD	\$598,415,047	\$598,415,047
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$308,668,146	\$598,415,047	\$907,083,193

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	TBD	\$70,490,459	\$70,490,459
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$55,868,664	\$70,490,459	\$126,359,123

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES; MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	TBD	\$692,143,775	\$692,143,775
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$452,028,279	\$692,143,775	\$1,144,172,054
<i>Grand Total</i>			\$816,565,089	\$1,361,049,281	\$2,177,614,370

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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EXPLANATION

This request covers the period July 1, 2020 through June 30, 2021 (prior contract period was a ten month period). The amounts herein make an initial actuarial estimate for the costs of deferred care from the prior contract period. The budget amounts in the fiscal tables reflect enrollment experience and trend as a result of the public health emergency and the maintenance of effort requirements. Thus far through May 22, 2020, from the date of the PHE, total enrollment has increased overall by more than 7% with the Granite Advantage Health Care Program (GAHCP) over 11%. For State Fiscal Year 2021, enrollment is projected to increase additionally 5.3% for the standard population and 16.5% for the GAHCP.

There is undoubtedly, a high level of uncertainty for future COVID-19 treatment and testing costs, and the acuity of the spike in new enrollment due to the effects of the COVID-19 and the PHE and related economic conditions. Additionally, the impacts on future utilization and deferred care, unrelated to COVID-19 are not reliably known. Therefore, DHHS proposes a retroactive actuarial rate refresh based on experience from the first quarter of the contract back to July 1, 2020 to incorporate more recent actuarial experience, HB 4 rate adjustments, and any further legislative policy changes. The retroactive actuarial rate refresh will necessitate another contract amendment anticipated in February 2021.

Summary of Changes

The amendment to the three (3) MCM capitated and risk-based vendor Agreements, including capitation rate adjustments for September 2019 to June 2020, and July 2020 through June 2021, as well as Exhibit A narrative contract changes, reflect the following changes:

The State Fiscal Year 2021 capitation rates below reflect three program changes from the September 2019 to June 2020 capitation rates.

They are:

1. Revised rate cell structure that incorporates the GAHCP Behavioral Health population into the existing Behavioral Health rate cells and a separate Children's Health Insurance Program (CHIP) rate cell;
2. Targeted savings opportunities through increased care management activities consistent with the MCM contract effective September 1, 2019; and
3. Implementation of a hospital directed payment to promote access to high-quality acute care services provided by critical access and non-critical access hospitals across New Hampshire.

The State Fiscal Year 2021 capitation rates include a continued five million dollar directed payment to community mental health centers (CMHCs), and a new thirty million dollar directed payment to hospitals (both subject to CMS approval). While the amounts are included in the MCO capitation rates, the MCOs are not at-risk for the amount of these directed payments. Both directed payments are included to support quality and access initiatives of the MCM Program.

Capitation Rate Tables 1A and 1B below show the statewide rate change by population compared to the September 2019 to June 2020 capitation rates included in the April 22, 2020 rate certification. The two tables compare rates with and without the new hospital directed payment.

Table 1A capitation rates exclude the new hospital directed payment.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Table 1A New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2021 Capitation Rate Change Based on Projected SFY 2021 Enrollment by Rate Cell Excluding Hospital Directed Payment			
Population	September 2019 to June 2020 Capitation Rate	SFY 2021 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$329.36	\$342.73	4.1%
CHIP*	199.95	196.42	-1.8%
Behavioral Health Population	1,445.57	1,430.00	-1.1%
Total Standard Medicaid	\$405.24	\$414.21	2.2%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.85	\$1,239.29	0.2%
Non-Medically Frail	475.21	467.84	-1.6%
Behavioral Health Population**	999.67	2,046.46	104.7%
Total GAHCP	\$621.60	\$651.65	4.8%
Grand Total	\$469.36	\$484.58	3.2%

*The September 2019 to June 2020 capitation rates did not have a separate rate cell for the CHIP population. Most CHIP members were included in the Low Income Children and SED rate cells. The SFY 2021 CHIP population includes CHIP members enrolled in the CHIP and SED rate cells.

**The September 2019 to June 2020 GAHCP capitation rates did not have a separate rate cell for the GAHCP behavioral health population. GAHCP behavioral health population members were included in the Medically Frail and Non-Medically Frail capitation rates. The GAHCP behavioral health population will receive the behavioral health population capitation rates for SFY 2021.

Table 1B includes capitation rates with inclusion of the new hospital directed payment.

Table 1B New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2021 Capitation Rate Change Based on Projected SFY 2021 Enrollment by Rate Cell Including Hospital Directed Payment			
Population	September 2019 to June 2020 Capitation Rate	SFY 2021 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$329.36	\$353.36	7.3%
CHIP*	199.95	200.30	0.2%
Behavioral Health Population	1,445.57	1,446.23	0.0%
Total Standard Medicaid	\$405.24	\$424.48	4.7%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.85	\$1,273.88	3.0%
Non-Medically Frail	475.21	486.18	2.3%
Behavioral Health Population**	999.67	2,069.51	107.0%
Total GAHCP	\$621.60	\$672.86	8.2%
Grand Total	\$469.36	\$498.09	6.1%

*The September 2019 to June 2020 capitation rates did not have a separate rate cell for the CHIP population. Most CHIP members were included in the Low Income Children and SED rate cells. The SFY 2021 CHIP population includes CHIP members enrolled in the CHIP and SED rate cells.

**The September 2019 to June 2020 GAHCP capitation rates did not have a separate rate cell for the GAHCP behavioral health population. GAHCP behavioral health population members were included in the Medically Frail and Non-Medically Frail capitation rates. The GAHCP behavioral health population will receive the behavioral health population capitation rates for SFY 2021.

It should be emphasized that capitation rates are a projection of future costs for an efficient MCO based on a set of assumptions. Actual MCO costs will be dependent on each MCO's

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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situation and the extent to which future experience conforms to the assumptions made in the capitation rate development calculations.

The amendment also includes narrative and other content changes as described below.

They include:

1. Transitional housing program services and community residential services wrap-around services and supports benefit start date from July 1, 2020 to July 1, 2021;
2. Reference to payments standards for directed payments described in actuarial certification materials for the rating period;
3. Change in delivery timeframes for DHHS notice of MCM Withhold and Incentive Program Guidance from within ninety (90) calendar days of the start of the program year to August 1st each year;
4. Explanation that any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period;
5. With alternate instructions from CMS, full replacement of CMS-mandated contract language that directs administration and funds previously appropriated for the GAHCP community engagement requirements administered through the managed care contracts;
6. Provision for a retroactive rate refresh effective July 1, 2020 targeted for February 2021 to address the PHE and related economic and healthcare conditions;
7. Inclusion of a risk corridor protection for the July 2020 to June 2021 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic and the PHE; and
8. Technical corrections to Exhibit N (Liquidated Damages) referenced contract provisions.

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His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 6 of 6

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 90% Federal and 10% Other; funds for the Child Health Insurance Program are 67.88% federal as appropriated by Congress and 32.12% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51.01% Federal as appropriated by Congress, 22.56% General and 26.43% Other funds.

In the event that the non-federal Other funds for the GAHCP necessary to cover the program are not sufficient, the projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,

Lori A. Shibinette
Lori A. Shibinette
Commissioner
File

*The Department of Health and Human Services' Mission is to join communities and families
in providing opportunities for citizens to achieve health and independence.*



Lori A. Shibley
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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April 24, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to retroactively amend existing agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schrafft's City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM). The shared price limitation remains unchanged, not to exceed \$816,565,089, in State Fiscal Year 2020, retroactive to September 1, 2019 with no change to the completion date of August 31, 2024, effective upon Governor and Executive Council approval. After reconciliation of membership, however, we did a reallocation of funds within the price limitation as reflected in the accounting tables.

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 77.6% Federal and 22.4% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 22.7% General and 26.3% Other funds.

This agreement was originally approved by the Governor and Executive Council on March 27, 2019 (Tabled Late Item A), and subsequently amended on April 17, 2019 (Item #9), and December 18, 2019 (Item #15).

Funds are available in the following accounts for State Fiscal Year 2020, and are anticipated to be available in the State Fiscal Years 2021 through 2025, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for State Fiscal Year 2020.

His Excellency, Governor Christopher T. Sununu
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**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$316,129,763	(\$7,461,617)	\$308,668,146
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$316,129,763	(\$7,461,617)	\$308,668,146

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$55,047,886	\$820,778	\$55,868,664
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$55,047,886	\$820,778	\$55,868,664

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$445,387,440	\$6,640,839	\$452,028,279
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$445,387,440	\$6,640,839	\$452,028,279

Grand Total	\$816,565,089	\$0	\$816,565,089

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and the Honorable Council
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EXPLANATION

This request is retroactive to September 1, 2019 in order to reallocate 1.5% of the capitation payments to ensure access to care for Medicaid beneficiaries and help provide financial stability for safety-net providers. Network providers' provision of access to Medicaid beneficiaries could decrease without consideration of the impact of COVID-19. The directed payments described herein are intended to help, in part, providers remain available to beneficiaries and ensure network adequacy under CMS regulations.

In addition, this amendment will address the CMS requirement to strike contract language that directs administration and funds previously appropriated for the Granite Advantage Health Care Program's (GAHCP) community engagement requirements administered through the managed care contracts. This is because Community engagement requirements have been vacated by the court.

Summary of Changes

DHHS therefore proposes to make the following changes to components of the capitation rates in order to fund the proposed directed payment funding pool:

1. Reduce service costs by 1.5% for all services to recognize the expected net impact of reductions in non-emergency and elective service costs due to the COVID-19 pandemic social distancing guidelines, increased COVID-19 treatment costs, the impact of waiving certain prior authorization requirements, and reduced population acuity due to projected enrollment increases related to the recession
 - a. The MCOs have agreed to continue their capitation arrangement with the community mental health centers (CMHCs) at current payment levels and waive any related maintenance of effort (MOE) provisions for state fiscal year (SFY) 2020.
2. Reduce the per member per month (PMPM) administrative allowance for all rate cells by 1.5% to recognize that significantly fewer MCM program members are enrolled in care management programs compared to the 15% expectation in the MCM contract.
3. Further reduce the administrative allowance for the GAHCP Non-Medically Frail population by \$0.45 PMPM to remove costs related to the GAHCP work and community engagement requirement. The related funding is repurposed for the directed payment pool.
4. Reduce the gain/loss margin to reflect the shifting of revenue from at-risk services to the new non-risk directed payments. The gain/loss margin still represents 1.5% of at-risk revenue.
5. Calculate the amount available for the new directed payment funding pool, which is approximately \$11.7 million assuming the original projected enrollment level (i.e., not incorporating likely enrollment growth resulting from the recession).
6. The original CMHC directed payment remains unchanged.
7. The PMPM premium tax allowance remains unchanged because the capitation rates by rate cell are unchanged after the reallocation by component.

Safety-net Provider Directed Payments

Pending CMS approval, DHHS will require each MCO to pay a percentage distribution and initial allocation for specific qualifying services provided by the six safety-net provider classes based on January 2019 to June 2019 MCO encounter payments as described in Table 1 below.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Safety-net Provider Class	Percentage Distribution of January to June 2019 MCO Payments for Selected Services Only	Approximate September 2019 to June 2020 Direct Payment (Total) ¹	Approximate September 2019 to June 2020 Direct Payment (Monthly) ¹
FQHCs and RHCs	32.0%	\$3,744,000	\$374,400
Critical Access Hospitals	29.8%	3,486,600	348,660
SUD Residential Treatment	16.8%	1,965,600	196,560
Home Health	4.9%	573,300	57,330
Private Duty Nursing	8.8%	1,029,600	102,960
Personal Care	7.7%	900,900	90,090
Total Pool	100.0%	\$11,700,000	\$1,170,000

¹ Approximate values of the direct payment pool are based on the initial enrollment projections in the January 14, 2020 rate setting report. Actual monthly pool funding will be determined by actual MCM program enrollment multiplied by the PMPM directed payment funding for each rate cell in the September 2019 to June 2020 MCM program capitation rates.

An identified portion of the actuarially sound per member per month capitation payment to the MCOs multiplied by the member months the plan is paid for the month will form a pool to be used every month to make percentage add-on payments to the defined safety-net provider classes. The pool will be 1.5% of the capitation payments made to the MCOs, or approximately \$12 million for the September 2019 to June 2020 contract year (depending on actual enrollment). DHHS will establish the percentage of the pool that will be allocated to a separate sub-pool for each of the six safety-net provider classes based on historical MCO payments to these providers.

At the end of the month, the amount in each sub-pool will be divided by the payments made by the MCOs to the defined safety-net provider class for qualifying services adjudicated in the month. This calculation will determine the amount of the uniform percentage add-on for the month. The additional payments will be sent to the safety-net providers in the following month. It is anticipated that payments will be made on the following schedule:

- May 2020 payment: based on September 2019 to March 2019 encounters
- June 2020 payment: based on April 2020 encounters
- July 2020 payment: based on May 2020 encounters
- August 2020 payment: based on June 2020 encounters

Every add-on payment will be directly tied to a qualifying paid encounter, and include the ability to tie each payment to a specific service provided to a specific beneficiary through the data consistent with the managed care rule. As warranted to account for changes in the provider environment, CMS has advised that DHHS may amend its directed payment request.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Elements Supporting CMS Approval

The CMS requirement for a directed payment approval under the COVID-19 parameters is to require implementation of a risk corridor for the September 2019 through June 2020 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

In addition, as recommended in CMS guidance documents, additional administrative changes include:

1. For the September 2019 to June 2020 contract year, DHHS shall waive the quality withhold provisions of the Agreement due to the impact of the COVID-19 pandemic.
2. For the May 1, 2020 to June 30, 2020 time period, DHHS shall modify the auto-assignment algorithm to incorporate equal auto-assignment among the three MCOs due to atypical enrollment increase.

Should the Governor and Executive Council not authorize this request beneficiary access and provider stability of safety-net providers will be at greater risk.

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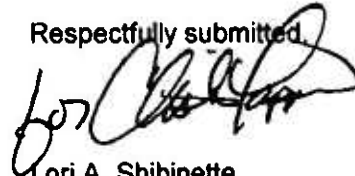
His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 6 of 6

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 93% federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 77.6% federal as appropriated by Congress and 22.4% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 22.7% General and 26.3% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, sums necessary to cover a projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shibinette
Commissioner

*The Department of Health and Human Services' Mission is to join communities and families
in providing opportunities for citizens to achieve health and independence.*

15 mac



Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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December 4, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to **retroactively** amend existing agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schraffts City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, and by increasing the shared price limitation by \$18,750,925 from \$797,814,164 to an amount not to exceed \$816,565,089, in State Fiscal Year 2020, retroactive to September 1, 2019 with no change to the completion date of August 31, 2024, effective upon Governor and Executive Council approval.

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 77.6% Federal and 22.4% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 22.7% General and 26.3% Other funds.

This agreement was originally approved by the Governor and Executive Council on March 27, 2019 (Tabled Late Item A), and subsequently amended on April 17, 2019 (Item #9).

Funds are available in the following accounts for State Fiscal Year 2020 and are anticipated to be available in the State Fiscal Years 2021 through 2025, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for State Fiscal Year 2020.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$299,465,981	\$16,663,782	\$316,129,763
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD

Sub-Total \$299,465,981 \$16,663,782 \$316,129,763

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$54,818,300	\$229,586	\$55,047,886
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD

Sub-Total \$54,818,300 \$229,586 \$55,047,886

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$443,529,883	\$1,857,557	\$445,387,440
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD

Sub-Total \$443,529,883 \$1,857,557 \$445,387,440

Grand Total	\$797,814,164	\$18,750,925	\$816,565,089

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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EXPLANATION

This request is retroactive because of the delay in adopting a biennial budget and the need to update the capitated rates to reflect the various provisions of the budget that are incorporated into the Medicaid Care Management Program.

The amendment to the three (3) Medicaid Care Management (MCM) capitated and risk-based Agreements, including adjustments for September 2019 to June 2020 capitation rates for the MCOs and Exhibit A narrative contract changes, reflect the following changes:¹

Minimum Durable Medical Equipment (DME) fee schedule: Effective January 1, 2020, DHHS shall implement a minimum fee schedule DME services. The estimated impact of this change is approximately \$3.2 million over the January 2019 through June 2020 period.

Psychiatric boarding services: To improve continuity of care for mentally ill MCM members, DHHS shall fund psychiatric consultation services for individual in a psychiatric boarding situation. These services shall be effective March 1, 2020. The estimated impact of this change is approximately \$0.1 million over the March 2020 through June 2020 period.

Fee schedule updates: In accordance with annual CMS updates, reimbursement adjustments reflect the State Fiscal Year 2020 Federally Qualified Health Center (FQHC) encounter rates and the October 2019 (Diagnosis-Related Group) DRG rates.

Boston Children's Hospital (BCH) service funding: Funding for inpatient and outpatient BCH services shall reflect recent expenditure patterns prompting implementation of a risk pool in order to better allocate funds. As a result, claims incurred at the facility shall be excluded from stop-loss protections to avoid unintended interactions between the MCM Program's risk pool and stop-loss risk protection features. The estimated impact of this change is approximately \$1.4 million over the September 2019 through June 2020 period.

Non-Emergency Medical Transportation (NEMT) and Community Mental Health Center (CMHC) service costs: Increases in the Non-Medically Frail population's service costs for NEMT and CMHC costs for the January 2019 to June 2019 period warrant an increase to the base period data. The estimated impact of this change is approximately \$3.1 million over the September 2019 through June 2020 period.

MCO supplemental pharmacy rebates: Review of rebate eligible therapeutic classes revealed current spending did not support the preliminary 0.5% supplemental pharmacy rebate assumption; therefore, the rebate assumption is reduced from 0.5% to 0.1%.

Medically frail acuity adjustment: Review of emerging medical loss ratio (MLR) experience for the Medically Frail population indicated a likely difference in member health acuity between the base data period and emerging experience warrants adjustment to the base period data. The estimated impact of this change is approximately \$7.9 million over the September 2019 through June 2020 period.

Medicaid provider rate increases: House Bill 4, Section 348, of the 2019 NH Regular Legislative Session, directs increases to most Medicaid provider rates (excluding prescription drugs, designated receiving facility (DRF), and substance use disorder (SUD) residential treatment services), including State Plan Services and Waiver Programs by 3.1% effective

¹ Federal law requires managed care rates be reviewed no less frequently than a 12-month period. The Department aligns this process with the State Fiscal Year. The certified rate established for the program reflected in this contract is within the Department's budget for State Fiscal Year 2020. As in the past, the Department and Milliman will work with the legislature through the budget process to ensure the program is funded consistent with the budget.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council,
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January 1, 2020, and an additional 3.1% effective January 1, 2021. The estimated impact of this change is approximately \$9.6 million over the January 2020 through June 2020 period.

Designated Receiving Facility (Involuntary) beds and rate increases: House Bill 4, Section 356, of the 2019 NH Regular Legislative Session, authorizes 8 to 10 new DRF beds, and increases the diagnosis related group (DRG) base rate reimbursement for all existing and newly established DRF beds when certain conditions are met. The new rates and additional beds are targeted for implementation on January 1, 2020. The estimated impact of the change is approximately \$2.2 million for the January 2020 through June 2020 period.

Mobile crisis team (MCT): Senate Bill 11, of the 2019 NH Regular Legislative Session, directs DHHS to create a new adult MCT to supplement those already in place. The new MCT is targeted for implementation on April 1, 2020. The estimated impact of this change is \$0.3 million over the April 2020 through June 2020 period.

The rate adjustments for all of the above program changes are for the ten month capitation rate period for Standard Medicaid and NH Granite Advantage Health Care Program for the September 2019 through June 2020 period with comparison to the previously approved rates are described in Table 1 below. The adjustment period is only 10 months because the prior contract was extended by two months to help effectuate the transition period for the new MCO and the new contract, which was approved by the Executive Council for a September 1, 2019 start date. The Department's actuary, Milliman, has certified a rate that is actuarially sound for this program.

Table 1 New Hampshire Department of Health and Human Services Medicaid Care Management Program September 2019 to June 2020 Capitation Rate Change Based on Projected September 2019 to June 2020 MCO Enrollment by Rate Cell			
Population	Original September 2019 to June 2020 Capitation Rate (March 4, 2019 Report)	Revised September 2019 to June 2020 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$316.28	\$325.85	3.0%
CHIP*	197.36	205.47	4.1%
Behavioral Health Population	1,387.60	1,435.06	3.4%
Total Standard Medicaid	\$390.19	\$402.67	3.2%
Granite Advantage Health Care Program			
Medically Frail	\$1,028.86	\$1,242.47	20.8%
Non-Medically Frail	486.09	475.18	-2.2%
Total GAHCP	\$590.15	\$622.28	5.4%
Total	\$446.21	\$464.19	4.0%

*The CHIP capitation rate is an average of the specific rate cells in which CHIP members are enrolled. We do not develop a CHIP specific capitation rate.

His Excellency, Governor Christopher T. Sununu
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In addition, Exhibit A narrative contract changes include:

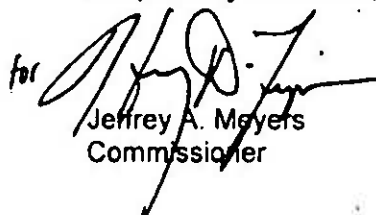
1. Amendment #1 edits carried forward, with adjustments as needed.
2. Transitional housing program services and community residential services: Coverage for these supportive services has been adjusted to reflect a July 1, 2020 start date to correspond with related Request for Proposals activities.
3. Provider payment: Clarifications to provider payments are dependent upon New Hampshire Medicaid fee schedules.
4. Drug Utilization Review (DUR) program: Inclusion of contract provisions to address new federal compliance requirements for the MCM Program's DUR program.
5. Technical corrections: Technical corrections include edits to pharmacy encounter date submission timeframes.
6. Zolgensma: Addition of gene therapy medication, Zolgensma, as a drug covered by New Hampshire Medicaid effective September 1, 2019 due to its extremely high cost and low incidence rate, which makes cost for the treatment difficult to predict for inclusion in MCM capitation rates, including related risk protection processes.
7. Hepatitis C medications: With stabilization of treatment demand, Hepatitis C prescription drugs are carved into the program starting September 2019.
8. Downside risk mitigation: Inclusion of a downside risk mitigation process for the Granite Advantage Health Care Program (GAHCP) Medically Frail and Non-Medically Frail populations for the September 2019 through June 2020 period.
9. Local Care Management: The contract reflects a terminology change, "Local Care Management Network(s)", to better reflect the nature of the program's local care management model.

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 93% federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 77.6 federal as appropriated by Congress and 22.4% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 22.7% General and 26.3% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, sums necessary to cover a projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,

for 
Jeffrey A. Meyers
Commissioner

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

Jeffrey A. Meyers
Commissioner

Henry D. Lipman
Director

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April 1, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services Office, to amend three (3) Agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schraffts City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, by changing the program start date from July 1, 2019 to September 1, 2019 to accommodate sufficient time for readiness activities needed to effectuate a well-executed implementation of health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, and by decreasing the price limitation by \$126,335,836 from \$924,150,000 to an amount not to exceed \$797,814,164 in State Fiscal Year 2020, for period September 1, 2019 through June 30, 2020, effective upon Governor and Executive Council approval, with a change to the completion date of August 31 2024, from June 30, 2024. The original Agreements were approved by Governor and Executive Council approval on March 27, 2019, Tabled Late Item A (Tabled by Governor and Executive Council on February 20, 2019).

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 78.8% Federal and 21.2% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 24.3% General and 24.7% Other funds.

Funds are anticipated to be available in the following account(s) for State Fiscal Years (SFY) 2020 through 2025 upon the availability and continued appropriation of funds in the future operating budgets. The Centers for Medicare and Medicaid Services (CMS) requires that managed care rate certifications must be done on no more than a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each state fiscal year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how this contract aligns with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for SFY 2020.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
OFC MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$360,150,000	(\$60,684,019)	\$299,465,981
SFY 2021	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$360,150,000	(\$60,684,019)	\$299,465,981

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
OFC MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/ Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$59,700,000	(\$4,881,700)	\$54,818,300
SFY 2021	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$59,700,000	(\$4,881,700)	\$54,818,300

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/ Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$504,300,000	(\$60,770,117)	\$443,529,883
SFY 2021	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$504,300,000	(\$60,770,117)	\$443,529,883
Grand Total			\$924,150,000	(\$126,335,836)	\$797,814,164

EXPLANATION

The purpose of this request is to amend the three (3) Medicaid Care Management (MCM) capitated, and risk-based Agreements by changing the program start date from July 1, 2019 to September 1, 2019. The amendment is necessary to provide a sufficient readiness ramp up period for the Department and the Contractors known as the Managed Care Organizations (MCOs) so the health care services to 180,000 eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, are implemented smoothly, and by decreasing the price limitation by (\$126,335,836) from \$924,150,000 to an amount not to exceed \$797,814,164 in State Fiscal Year 2020, September 2019-June 2020.

The proposed change in program start date, to a later date, was necessary to provide Governor and Executive Council sufficient time to review the new contracts, hold two informational hearings, and to allow the Department and the MCOs the needed time for readiness to occur for the new Agreements. These three (3) MCOs will serve approximately 180,000 members including pregnant women, children, parents/caretakers, non-elderly, non-disabled adults under the age of 65, and individuals who are aged, blind or disabled, among others, as described in the Medicaid Care Management (MCM) contracts. The MCOs will cover the acute care, behavioral health, and pharmacy services for all Members and work with the Department to address the crucial social determinants of health in accordance with the attached MCM contracts.

The MCOs will provide a person-centered, integrated, and comprehensive delivery system that offers a very substantial array of accessible Medicaid services, taking into account each Member's physical well-being, behavioral health (mental health and substance use disorders), and social circumstances. The Department will challenge its MCO partners to work responsively with the provider community and MCM Members to improve access to care and promote healthy behaviors. New Hampshire's MCM program will incentivize value over volume, enhance program efficiency, and hold MCOs accountable for demonstrable improvements in health outcomes.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Table One represents a ten-month year capitation rate for the Standard Medicaid and the NH Granite Advantage Health Care Program for the period September 2019 through June 2020 with a comparison to the SFY 2020 rates in the February 15, 2019 signed contracts approved by the Governor and Executive Council of March 27, 2019 (Tabled, 2/20/2019 Late item #A). This allows alignment with State of New Hampshire fiscal year through SFY 2024. The change to the completion date of August 31 2024 is requested to allow for the full 60-month contract that was specified in the request for proposals.

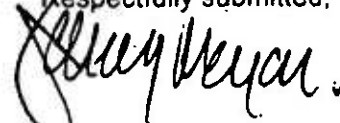
Table 1 New Hampshire Department of Health and Human Services Medicaid Care Management Program Comparison of SFY 2020 to September 2019 to June 2020 Capitation Rates Based on Projected Enrollment by Rate Cell			
Population	SFY 2020 Capitation Rates	September 2019 to June 2020 Capitation Rates	Percentage Change
Standard Medicaid			
Base Population	\$315.15	\$316.28	0.4%
CHIP*	196.71	197.36	0.3%
Behavioral Health Population	1,386.51	1,387.60	0.1%
Total Standard Medicaid	\$389.03	\$390.19	0.3%
Granite Advantage Health Care Program			
Medically Frail	\$1,025.07	\$1,028.86	0.4%
Non-Medically Frail	482.80	486.09	0.7%
Total GAHCP	\$586.30	\$590.15	0.7%
Total	\$444.28	\$446.21	0.4%

*The CHIP capitation rate is an average of the specific rate cells in which CHIP members are enrolled. We do not develop a CHIP specific capitation rate.

Area served: Statewide. Source of Funds: Funds for Granite Advantage Health Program are 93% Federal as appropriated by Congress and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 78.8% Federal as appropriated by Congress and 21.2% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 24.3% General and 24.7% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, consistent with RSA 126-AA:3, no state general funds shall be deposited into the fund and medical services for this population would end consistent with RSA 126-AA:3, VI and the terms and conditions of the federal waiver issued by the Centers for Medicare and Medicaid Services.

Respectfully submitted,



Jeffrey A. Meyers
Commissioner



Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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February 15, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to enter into Agreements with, AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schraffts City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, in an amount, for State Fiscal Year 2020 shared by all vendors, not to exceed \$924,150,000, effective upon Governor and Executive Council approval, with providing services to members on July 1, 2019 through the completion date of June 30, 2024.

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 79.4% Federal and 20.6% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 24.3% General and 24.7% Other funds.

Funds are anticipated to be available in the following account(s) for State Fiscal Years (SFY) 2020 through 2024 upon the availability and continued appropriation of funds in the future operating budgets. The Centers for Medicare and Medicaid Services (CMS) requires that managed care rate certifications must be done on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each state fiscal year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how this contract aligns with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for SFY 2020.

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: OFC MEDICAID SERVICES, GRANIT ADVANTAGE HEALTH PROGRAM
TRUST FUND

State Fiscal Year	Class / Account	Class Title	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$360,150,000
SFY 2021	101-500729	Medical Payments to Providers	TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD
		Sub-Total:	\$360,150,000

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: OFC MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$59,700,000
SFY 2021	101-500729	Medical Payments to Providers	TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD
		<i>Sub-Total:</i>	\$59,700,000

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$504,300,000
SFY 2021	101-500729	Medical Payments to Providers	TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD
		<i>Sub-Total:</i>	\$504,300,000
		Grand Total:	\$924,150,000

EXPLANATION

The purpose of this request is to enter into capitated, risk-based Agreements to provide acute care and other medical services to eligible and enrolled Medicaid participants New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management. ~~These three (3) Vendors will serve approximately 180,000 members including pregnant women, children, parents/caretakers, non-elderly, non-disabled adults under the age of 65, and individuals who are aged, blind or disabled, among others, as described in the Medicaid Care Management (MCM) contracts.~~ The Managed Care Organizations (MCOs) will cover the acute care, behavioral health, and pharmacy services for all Members and work with the Department of Health and Human Services (DHHS) to address the crucial social determinants of health in accordance with the attached MCM contracts.

The MCO Vendors will provide a person-centered, integrated, and comprehensive delivery system that offers a very substantial array of accessible Medicaid services, taking into account each Member's physical well-being, behavioral health (mental health and substance use disorders), and social circumstances. DHHS will challenge its MCO partners to work responsively with the provider community and MCM Members to improve access to care and promote healthy behaviors. New Hampshire's MCM program will incentivize value over volume, enhance program efficiency, and hold MCOs accountable for demonstrable improvements in health outcomes.

Two of the Vendors, Boston Medical Center Health Plan Inc., and Granite State Health Plan Inc., are respectively otherwise known as Well Sense Health Plan, and New Hampshire Healthy Families. The Department presently contracts with both of these Vendors to provide New Hampshire's Medicaid Care Management program.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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I. Procurement Process

These contracts represent the culmination of the Department's first re-procurement of the MCM program since its commencement in December 2013. The Department's process for the development of the program reflected in the contracts and the contracts themselves represent a significant improvement over the prior procurement process and the program itself. The Department -- for the first time ever -- put out the Request for Proposals for public comment and held public information sessions in each of the Executive Council Districts last July in Concord, Keene, Manchester, Nashua, Littleton and Portsmouth before it was issued to potential respondents.

These three (3) Vendors were selected through a competitive bid process. A Request for Proposals RFP-2019-OMS-MANAG-02 was posted on the Department of Health and Human Services' web site from August 30, 2018 through October 31, 2018. A mandatory bidder's conference was held on September 7, 2018. In-person attendance at the Mandatory Bidder's Conference was a requirement to submit a proposal. The Department received four (4) proposals. The proposals were reviewed and scored by a team of individuals with program specific knowledge. The Bid Summary is attached.

II. Central Features of the New MCM Program

This procurement was also focused on improving the program for beneficiaries and providers and introducing many new features. The goals of the new MCM program are to

- Improve care of Members
- Improve health outcomes
- Reduce inpatient hospitalization and re-admissions
- Improve continuity of care across the full continuum of care
- Improve transition planning when care is completed
- Improve medication management
- Reduce unnecessary emergency services
- Decrease the total cost of care
- Increase member satisfaction
- Improve provider participation in the program

In order to help achieve these goals, the new contracts make many changes in the current program. These include the following:

- **Additional Care Coordination and Care Management** resources to provide significantly more beneficiary support to those in greater need, including providing it at a local level. MCOs must provide Care Management for at least 15% of high-risk/high-need members, and MCOs must conduct local care management or contract with a designated care management entity for at least 50% of high-risk/high-need members.
- **Behavioral Health (Mental Health and Substance Use Disorder)** provisions support integration of care with physical health, implementation of the Department's new 10-year Mental Health Plan, and advance SUD treatment. MCOs are required to take into account each person's physical health, behavioral health (mental health and substance use disorders), and social and economic needs. MCOs are required to work with Members, Providers, integrated delivery networks (IDNs), and community mental health

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 4 of 6

programs (CMHPs) to integrate physical health and behavioral health and address social determinants of health that affect health outcomes and the cost-effectiveness of care.

- **Emergency Room Waiting Measures** include the provision of additional clinical staff to support the provision of services in hospital emergency departments to reduce the need for Members to wait for inpatient services.
- **Support the Community Mental Health Centers and Substance Use Disorder Providers** by entering into capitated payment arrangements with Community Mental Health Programs and Providers, and reimburse substance use disorder providers at rates no less than the DHHS fee-for-service rates. MCOs must also contract with any willing peer recovery provider.
- **Alternative Payment Models (APMs)** provisions require MCOs to incentivize value over volume and significantly reduce current fee for service billing arrangements.
- **Community Engagement** specifies a role for the MCOs to support beneficiaries in fulfilling the Community Engagement requirement, including assisting their members with understanding qualifying activities and exemptions.
- **New Provider Supports** require MCOs to implement prompt and accessible credentialing and re-credentialing processes that will be used to conduct provider outreach and support; standardize work processes to ensure efficient implementation of the program and minimal provider burden relative to claims billing processes, reporting, and prior authorizations; meet prompt payment requirements and pay claims based on the effective date of the Current Procedural Terminology code, and establish a provider grievance and appeals process.

- **Pharmacy Counselling and Management** are strengthened to help improve the safety and therapeutic benefits to beneficiaries and the economy of the program.
- **Beneficiary Choice and Competition** is increased by providing Medicaid beneficiaries with three high-quality MCOs from which to choose.

- **Incentives and opportunities for beneficiaries to participate in healthy behaviors** must be provided by MCOs to improve individual health.
- **Cost transparency** through reference based pricing and incentives to beneficiaries.
- **Accountability for results** is increasing because a share of payment to MCOs will be directly linked to their performance, ensuring accountability for results, particularly in high priority areas such as addressing substance use disorders, integrating physical and behavioral health, providing robust care management, and reducing unnecessary use of high-cost services.
- **Public Reporting** is an added contract element. Each selected MCO will be responsible for submitting an annual report to the Governor and the legislature reporting on how the MCO has addressed State priorities for the MCM Program, including those specified in RSA 126-AA and in other State statute, policies, and guidelines; what innovative programs it has established; how it is addressing social determinants of health of its members, and how it is improving the population health of the state and other key metrics of the program.
- **Heighten program compliance and integrity provisions** have been added that allow for liquidated damages to be applied to the MCOs around contractual performance; provisions that incent MCO performance around collections for third party liability and coordination of benefits; and general fraud waste and abuse.

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and the Honorable Council
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- **Medical Loss Ratio** is specified in the contract at a minimum amount of 85% that must be spent on service delivery to beneficiaries, any amount less is to be rebated back to the Program.

iii. Rate-making and Budget

The Department's actuary, Milliman, has certified a rate that is actuarially sound for this program. These rates are reflected in Table I below:

Table 1 New Hampshire Department of Health and Human Services SFY 2020 Capitation Rate Change Based on Projected SFY 2020 MCO Enrollment by Rate Cell			
Population	January 2019 to June 2019 Capitation Rate	SFY 2020 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$303.54	\$315.15	3.8%
CHIP*	188.36	196.71	4.4%
Behavioral Health Population	1,294.03	1,386.51	7.1%
Total Standard Medicaid	\$371.26	\$389.03	4.8%
Granite Advantage Health Care Program			
Medically Frail	\$993.36	\$1,025.07	3.2%
Non-Medically Frail	423.21	482.80	14.1%
Total GAHCP	\$532.03	\$586.30	10.2%
Total	\$416.29	\$444.28	6.7%

*The CHIP capitation rate is an average of the specific rate cells in which CHIP members are enrolled. We do not develop a CHIP specific capitation rate.

Federal law requires that managed care rates be reviewed no less frequently than a 12-month period. The Department aligns this process with the state fiscal year. Over the last several years, the rates have been reviewed and an amendment made to the MCM contracts in May or June for the fiscal year beginning on July 1st. In order to maintain actuarial soundness, the rates are also required to be reviewed in the event of significant program changes. For example, while the Department established rates for FY 2019 last spring, the Department was required to refresh and update the rates when the Medicaid expansion program was brought back into managed care on January 1, 2019 – in the middle of the state fiscal year.

This year, there are items in both the Governor's budget and in other legislation now pending that, if and when enacted, would require Milliman to revise the rates. Specifically, there are proposals to (i) raise the rates paid to community based designated receiving facilities, (ii) add transitional housing for persons who can be discharged from New Hampshire Hospital; (iii) add mobile crisis teams or other behavioral health crisis services. All of these

His Excellency, Governor Christopher T. Sununu
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additional services will have to be incorporated into the capitated rates for the managed care program consistent with their effective dates.

As a result, the Department anticipates that following the end of the legislative session, Milliman will review all program changes and any other relevant information, and adjust the rates as necessary. The Department would expect to bring an amendment to the contract in the September or October time frame for this purpose.

The certified rate established for the program that is reflected in this contract is within the Department's budget for state fiscal year 2020. Even though that the rates have been increased, a decline in the number of persons enrolled in Medicaid and a decline in the acuity of the population that has reduced expenditures in certain of the highest rate cells accounts for a reduction of total expenditure in the program within the current budget. As we have in the past, the Department and Milliman will work with the legislature in the budget process to ensure that the program is funded consistent with the budget.

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 93% Federal as appropriated by Congress and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 79.4% Federal as appropriated by Congress and 20.6% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 24.3% General and 24.7% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, consistent with RSA 126-AA:3, no state general funds shall be deposited into the fund and medical services for this population would end consistent with RSA 126-AA:3, VI and the terms and conditions of the federal waiver issued by the Centers for Medicare and Medicaid Services

Respectfully submitted,


Jeffrey A. Meyers
Commissioner

**State of New Hampshire
Department of Health and Human Services
Amendment #10 to the Medicaid Care Management Services Contract**

This 10th Amendment to the Medicaid Care Management Services contract (hereinafter referred to as "Amendment #10") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Boston Medical Center Health Plan Inc.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on March 27, 2019, (Tabled Late Item A), as amended on April 17, 2019 (Item #9), as amended on December 18, 2019 (Item #15), as amended on May 20, 2020 (Item #7A), as amended on June 10, 2020 (Item #6), as amended on January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), as amended on December 08, 2021 (Item #6-1), as amended on June 15, 2022 (Item # Tabled Item 20A), and as amended on December 21, 2022 (Item #13A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to modify the price limitation and modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify Form P-37, General Provisions; Block 1.8, Price Limitation, to read: \$5,928,058,454
2. Modify Exhibit A, Amendment #9 by replacing it in its entirety with Exhibit A, Amendment #10, which is attached hereto and incorporated by reference herein. Modifications to Exhibit A, Amendment #9 are outlined below:
 - a. Modify Exhibit A, Section 2.1.53.2, to read:

2.1.53.2. A Member cannot be required by the MCO to use the alternative service or setting. Beginning January 3, 2023, all In Lieu Of Services shall be reviewed for consideration and authorization in accordance with federal regulations, as appropriate. [42 CFR 438.3(e)(2)(i) - (iii); SMDL #23-001]
 - b. Modify Exhibit A, Section 3.13.1.1, to read:

3.13.1.1 The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.13 (Compliance with State and Federal Laws), and any laws, regulations or administrative rules effective after the execution of this Agreement. The MCO shall comply with any applicable federal and State laws that pertain to Member rights and ensure that its employees and Participating Providers observe and protect those rights. [42 CFR 438.100(a)(2)]
 - c. Modify Exhibit A, Section 3.13.1.3, to read:

3.13.1.3 The MCO shall comply with all aspects of the DHHS Sentinel Event Reporting and Review Policy PO.1003, and any subsequent versions and/or amendments;
 - d. Modify Exhibit A, Section 3.13.1.3.1, to read:

3.13.1.3.1 The MCO shall 1) cooperate with review of any reported sentinel event, and provide any

additional reporting information requested by DHHS, and 2) participate in a DHHS sentinel event review, if requested;

e. Modify Exhibit A, Section 3.15.1.3.1.3, to read:

3.15.1.3.1.3 For the period January 1, 2021 through August 31, 2024, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions.

f. Modify Exhibit A, Section 3.15.1.3.2.3, to read:

3.15.1.3.2.3 For the period January 1, 2021 through August 31, 2024, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions

g. Modify Exhibit A, Section 3.15.1.3.5.2, to read:

3.15.1.3.5.2 For the period January 1, 2021 through August 31, 2024, the Long Term Care Coordinator position is not required.

h. Modify Exhibit A, Section 3.15.1.3.8.7, to read:

3.15.1.3.8.7 For the period January 1, 2021 through August 31, 2024, the Housing Coordinator position is not required.

i. Modify Exhibit A, Section 3.15.2.2.3.1, to read:

3.15.2.2.3.1 For the period January 1, 2021 through August 31, 2024, the Psychiatric Boarding program's hospital-credentialed Provider position(s) are not required.

j. Modify Exhibit A, Section 3.15.2.3.1, to read:

3.15.2.3.1 For the period January 1, 2021 through August 31, 2024, the Staff for Members at New Hampshire Hospital position is not required.

k. Modify Exhibit A, Section 3.15.2.4.5, to read:

3.15.2.4.5 For the period January 1, 2021 through August 31, 2024, the Behavioral Health Staff position responsible for in-person housing assistance is not required.

l. Modify Exhibit A, Section 4.1.2, Covered Services Table, by adding Footnote #9, to read:

9 For the period July 1, 2021 through August 31, 2024, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

m. Modify Exhibit A, Section 4.1.2, Covered Services Table, by adding Footnote #10, to read:

10 Effective April 1, 2023, certain preventive, restorative, denture and other oral health services are carved-out of the MCM Program and covered under the State's contract with Delta Dental of New Hampshire, Inc. for eligible adults ages 21 years and over. Dental and oral health emergency services for Medicaid enrolled children and adults of all ages will continue to be Covered Services under the MCM Program.

n. Modify Exhibit A, Section 4.1.3.5.1, to read:

4.1.3.5.1 The MCO may provide Members with services or settings that are "In Lieu Of" Services or settings with prior approval and in accordance with federal regulations.

o. Modify Exhibit A, Section 4.1.3.5.1.1, to read:

4.1.3.5.1.1 Intentionally left blank.

p. Modify Exhibit A, Section 4.1.3.5.1.2, to read:

4.1.3.5.1.2 Intentionally left blank.

q. Modify Exhibit A, Section 4.1.3.5.1.3, to read:

4.1.3.5.1.3 Intentionally left blank.

r. Modify Exhibit A, Section 4.1.3.5.1.4, to read:

4.1.3.5.1.4 Intentionally left blank.

s. Add Exhibit A, Section 4.1.3.5.1.5, to read:

4.1.3.5.1.5 Any In Lieu of Services on record prior to January 3, 2023 and proposed for continuation must comply with CMS federal regulations beginning January 1, 2024. [42 CFR 438.3(e)(2)(i) - (iii); SMDL 1/4/23]

t. Modify Exhibit A, Section 4.1.3.5.2, to read:

4.1.3.5.2 Intentionally left blank.

u. Modify Exhibit A, Section 4.1.3.5.3, to read:

4.1.3.5.3 Beginning September 1, 2019, DHHS has authorized medical nutrition, diabetes self-management, and assistance in finding and keeping housing (not including rent), as In Lieu Of Services. This list may be expanded upon or otherwise modified by DHHS through amendments of this Agreement. Previously authorized In Lieu Of Services are scheduled for review and modification as may be necessary to meet federal regulatory compliance effective January 1, 2024.

v. Modify Exhibit A, Section 4.1.3.5.4, to read:

4.1.3.5.4 Intentionally left blank.

w. Modify Exhibit A, Section 4.1.3.5.5, to read:

4.1.3.5.5 The MCO shall support In Lieu of Services reporting, in accordance with federal regulations and Exhibit O.

x. Modify Exhibit A, Section 4.1.9.1.1, to read:

4.1.9.1.1 The MCO shall assume medical necessity for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility.

y. Modify Exhibit A, Section 4.3.6.2.2, to add:

Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)					
Distribution for Period Ending	Health Risk Assessment Completion	Encounter Data Timeliness Completeness and Quality	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Total Possible Members Awarded by Period
9/30/2023	2,000			1,000	3,000
12/31/2023	2,000		1,000		3,000
3/31/2024		1,000	1,000	1,000	3,000
6/30/2024		3,000			3,000
8/31/2024			2,000		2,000

z. Modify Exhibit A, Section 4.4.1.4.4.3.3 (8) to read:

(8) The cultural and linguistic capabilities of Participating Providers, including languages (including American Sign Language (ASL)) offered by the Provider or a skilled medical

interpreter at the Provider's office;

aa. Modify Exhibit A, Section 4.5.3.8, to read:

4.5.3.8 The MCO shall provide the Member and the Member's representative an opportunity to receive the Member's case file, free of charge prior and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b) - (c)]

bb. Modify Exhibit A, Section 4.10.8.1.1, to read:

4.10.8.1.1 As described in this Section 4.10.8, Local Care Management is optional for the period January 1, 2021 through August 31, 2024.

cc. Modify Exhibit A, Section 4.10.8.1.1.1, to read:

4.10.8.1.1.1 For the period July 1, 2021 through August 31, 2024, the term "Local Care Management" shall also mean "Care Management" in this Section 4.10.8.

dd. Modify Exhibit A, Section 4.11.2.2.1, to read:

4.11.2.2.1 For the period July 1, 2021 through August 31, 2024, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

ee. Modify Exhibit A, Section 4.11.5.7.2.1, to read:

4.11.5.7.2.1 For the period January 1, 2021 through August 31, 2024, the Housing Coordinator position is not required.

ff. Modify Exhibit A, Section 4.11.5.17.1.1., to read:

4.11.5.17.1.1. For the period January 1, 2021 through August 31, 2024, the Psychiatric Boarding program's hospital-credentialed Provider position(s) described in Sections 4.11.5.17.1 through 4.11.5.17.4, and 4.11.5.17.6 are not required.

gg. Modify Exhibit A, Section 4.15.5.4.1, to read:

4.15.5.4.1 The MCO shall limit any MOE clawback that is determined to fifty percent (50%) for the period July 1, 2023 through August 31, 2024; and limit MOE clawback to seventy percent (70%) for the period January 1, 2023 through June 30, 2023.

hh. Modify Exhibit A, Section 4.15.5.5.4, to read:

4.15.5.5.4 For the rating period July 1, 2023 through August 31, 2024, directed payment amounts determined by DHHS shall comprise a fee schedule adjustment or uniform dollar increase for assertive community treatment, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, consistent illness management and recovery services, and step down community residence beds for individuals dually diagnosed with serious mental illness and developmental disabilities, within the Community Mental Health Programs class of network providers as approved by CMS, including any alternate CMS-approved directed payment methodology.

ii. Modify Exhibit A, Section 4.15.5.6.2, to read:

4.15.5.6.2 For the rating period July 1, 2023 through August 31, 2024, directed payment remittance shall comprise a minimum fee schedule at least at the FFS rates established by DHHS for Community Residential Services.

jj. Modify Exhibit A, Section 4.15.10, by adding Subsection 4.15.10.1.5, to read:

4.15.10.1.5 For the rating period July 1, 2023 through August 31, 2024, MCO provider

reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

kk. Modify Exhibit A, Section 4.15.13, Subsection 4.15.13.1, by adding Subsection 4.15.13.1.4, to read:

4.15.13.1.4 For the rating period July 1, 2023 through August 31, 2024, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology. Qualified directed payments are tied to actual hospital services, including the number of inpatient discharges and outpatient visits reported by qualifying Providers.

ll. Modify Exhibit A, Section 4.15.14, Subsection 4.15.14.1, by adding Subsection 4.15.14.1.3, to read:

4.15.14.1.3 For the July 1, 2023 through August 31, 2024 rating period, the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 State Plan DRG fee schedule payment amounts described in Section 6.2.41.1.

mm. Modify Exhibit A, Section 4.15.15, Subsection 4.15.15.1, by adding Subsection 4.15.15.1.3, to read:

4.15.15.1.3 For the rating period July 1, 2023 through August 31, 2024, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

nn. Modify Exhibit A, Section 4.15.16.1, to read:

4.15.16.1 The MCO shall reimburse inpatient psychiatric services delivered in state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

oo. Modify Exhibit A, Section 4.15.16.1.2, to read:

4.15.16.1.2 For the rating period July 1, 2023 through August 31, 2024, the facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

pp. Modify Exhibit A, Section 4.15.16, by adding Subsection 4.15.16.2, to read:

4.15.16.2 The MCO shall reimburse inpatient psychiatric professional services delivered in the state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

qq. Modify Exhibit A, Section 4.15.16, by adding Subsection 4.15.16.2.1, to read:

4.15.16.2.1 For the rating period July 1, 2023 through August 31, 2024, directed payment amounts shall comprise minimum fee schedule payments at no less than the Medicare rates for inpatient psychiatric professional services delivered in the state-owned facilities.

rr. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.17, to read:

4.15.17 Payment Standard for Birthing Centers

ss. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.17.1, to read:

4.15.17.1 For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services at no less than NH Medicaid fee schedule rates.

- tt. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.18, to read:
 - 4.15.18 Qualifying Children's Hospitals
- uu. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.18.1, to read:
 - 4.15.18.1 The MCO shall remit directed payments to qualifying Children's Hospitals substantively serving NH Medicaid Members, in accordance with separate guidance, as follows:
- vv. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.18.2, to read:
 - 4.15.18.2 For the rating period July 1, 2023 through August 31, 2024, a directed payment add-on amount in addition to the MCO's negotiated rate shall be awarded to qualifying Children's Hospitals for each eligible inpatient and outpatient hospital service encounter as approved by CMS.
- ww. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.19, to read:
 - 4.15.19 Payment Standard for Ambulance Services
- xx. Modify Exhibit A, Section 4.15, by adding Subsection 4.15.19.1, to read:
 - 4.15.19.1 For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Providers for all ambulance and chair car Covered Services at no less than NH Medicaid fee schedule rates.
- yy. Modify Exhibit A, Section 5.3.7.3, to read:
 - 5.3.7.3 The MCO and the MCO's Providers and Subcontractors shall permit DHHS, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises at any time to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours.
- zz. Modify Exhibit A, Section 5.4.5.1.2, by adding Section 5.4.5.1.2.1, to read:
 - 5.4.5.1.2.1 The MCO shall be eligible for a maximum withhold capitation credit for the July 1, 2023 through August 31, 2024 rating period up to 0.15% based on Members who have completed their redeterminations between July 1, 2023 through October 31, 2023 as described in the MCM Withhold and Incentive Guidance.
- aaa. Modify Exhibit A, Section 5.4.5, by adding Section 5.4.5.2, to read:
 - 5.4.5.2 The MCO may be eligible for additional monetary incentives from the unearned withhold funds related to performance of activities to enhance care management and administrative practices including, but not limited to: fraud, waste, and abuse; medication reviews; polypharmacy; substance use disorder; and opioid treatment provider oversight and compliance as described in separate guidance.
- bbb. Modify Exhibit A, Section 6.2.12.1, to read:
 - 6.2.12.1 The September 2019 to August 31, 2024 capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.
- ccc. Modify Exhibit A, Section 6.2.12., by adding Section 6.2.12.3, to read:
 - 6.2.12.3 For the rating period July 1, 2023 through August 31, 2024 capitation rates include a preliminary acuity adjustment based on DHHS's intended PHE unwind process and a detailed redetermination schedule to estimate the percentage of Members expected to leave the Medicaid program for each redetermination cohort as explained in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid

Services for this rating period Amendment. The adjustment will be updated for Amendment #11 capitation rates, as appropriate.

ddd. Modify Exhibit A, Section 6.2.36.1, by adding Subsection 6.2.36.1.4, to read:

6.2.36.1.4 For the period July 1, 2023 through August 31, 2024, the attachment point shall be \$740,000.

eee. Modify Exhibit A, Section 6.2.38.2, to read:

6.2.38.2 For the contract period July 1, 2023 through August 31, 2024, the cost of the COVID-19 vaccines and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

fff. Modify Exhibit A, Section 6.2.41, to read:

6.2.41 For the July 1, 2023 through August 31, 2024 rating period, DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG codes 880-887, except as described in Section 6.2.41.3 below.

ggg. Modify Exhibit A, Section 6.3.4.1, to read:

6.3.4.1 For the period July 1, 2023 through August 31, 2024, the target MLR for at-risk services is 90.8% for Standard Medicaid and 89.9% for GAHCP based on the projected enrollment distribution for the rating period. Please note, each program's target MLR may change in future rate amendments as a result of changes to underlying assumptions, such as enrollment projections, emerging utilization experience, and the retroactive acuity adjustments, if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

hhh. Modify Exhibit A, Section 6.3.4.1.1, to read:

6.3.4.1.1 The minimum MLR is set on a program-wide basis for each major population, such that the maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). The minimum MLR shall be 88.3% for the Standard Medicaid population and 87.4% for the GAHCP population:

iii. Modify Exhibit A, Section 6.3.4.1.2, to read:

6.3.4.1.2 The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCOs will have a maximum loss of 2.0%. Based on the target MLRs, the maximum MLR shall be 94.3% for the Standard Medicaid population and 93.4% for the GAHCP population.

3. Modify Exhibit B, Amendment #9 by replacing it in its entirety with Exhibit B, Amendment #10, which is attached hereto and incorporated by reference herein.

4. Modify Exhibit O, Amendment #9 by replacing it in its entirety with Exhibit O, Amendment #10, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment remain in full force and effect. This Amendment shall be effective July 1, 2023, subject to Governor and Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

5/30/2023
Date

DocuSigned by:
Henry D. Lipman
Name: Henry D. Lipman
Title: Medicaid Director

Boston Medical Center Health Plan Inc.

5/30/2023
Date

DocuSigned by:
Heather Thiltgen
Name: Heather Thiltgen
Title: President and CEO

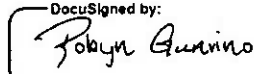
The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

5/30/2023

Date

DocuSigned by:



Name: Robyn Guarino

Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:

Title:



Medicaid Care Management
Services Contract

EXHIBIT A – AMENDMENT #10

SCOPE OF SERVICES

Medicaid Care Management Services Contract



New Hampshire Department of Health and Human Services
Medicaid Care Management Services
Exhibit A – Amendment #10

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Medicaid Care Management Services Contract



New Hampshire Department of Health and Human Services
Medicaid Care Management Services
Exhibit A – Amendment #10

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1 INTRODUCTION

1.1 Purpose

1.1.1 This Medicaid Care Management Agreement is a comprehensive full risk prepaid capitated Agreement that sets forth the terms and conditions for the Managed Care Organization's (MCO's) participation in the New Hampshire (NH) Medicaid Care Management (MCM) program.

1.1.2 ~~[Amendment #1:] All terms and conditions of the Agreement not inconsistent with this Agreement #1 remain in full force and effect.~~

1.2 Term

1.2.1 The Agreement and all contractual obligations, including Readiness Review, shall become effective on the date the Governor and Executive Council approves the executed MCM Agreement or, if the MCO does not have health maintenance organization (HMO) licensure in the State of New Hampshire on the date of Governor and Executive Council approval, the date the MCO obtains HMO licensure in the State of New Hampshire, whichever is later.

1.2.1.1 If the MCO fails to obtain HMO licensure within thirty (30) calendar days of Governor and Executive Council approval, this Agreement shall become null and void without further recourse to the MCO.

1.2.2 [Amendment #1:] The Program Start Date shall begin September 1, 2019, and the Agreement term shall continue through August 31, 2024.

~~[Base Contract:] The Program Start Date shall begin on July 1, 2019, and the Agreement term shall continue through June 30, 2024.~~

1.2.3 The MCO's participation in the MCM program is contingent upon approval by the Governor and Executive Council, the MCO's successful completion of the Readiness Review process as determined by DHHS, and obtaining HMO licensure in the State of New Hampshire as set forth above.

1.2.4 The MCO is solely responsible for the cost of all work during the Readiness Review and undertakes the work at its sole risk.

1.2.5 [Amendment #1:] If DHHS determines that any MCO will not be ready to begin providing services on the MCM Program Start Date, September 1, 2019, at its sole discretion, DHHS may withhold enrollment and require corrective action or terminate the Agreement without further recourse to the MCO.

~~[Base Contract:] If DHHS determines that any MCO will not be ready to begin providing services on the MCM Program Start Date, July 1, 2019, at its sole discretion, DHHS may withhold enrollment and require corrective action or terminate the Agreement without further recourse to the MCO.~~

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2 DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.1 **Adults with Special Health Care Needs**

2.1.1.1 "Adults with Special Health Care Needs" means Members who have or are at-increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age.

2.1.1.1.1 This includes, but is not limited to Members with: Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); a Severe Mental Illness (SMI), Serious Emotional Disturbance (SED), Intellectual and/or Developmental Disability (I/DD), Substance Use Disorder diagnosis; or chronic pain.

2.1.2 **Advance Directive**

2.1.2.1 "Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of New Hampshire, relating to the provision of health care when a Member is incapacitated. [42 CFR 489.100]

2.1.3 **Affordable Care Act**

2.1.3.1 "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted on March 30, 2010.

2.1.4 **Agreement**

2.1.4.1 "Agreement" means this entire written Agreement between DHHS and the MCO, including its exhibits.

2.1.5 **American Society of Addiction Medicine (ASAM) Criteria**

2.1.5.1 "American Society of Addiction Medicine (ASAM) Criteria" means a national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. The Criteria provides guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.¹

¹ The American Society of Addiction Medicine, "What is the ASAM Criteria"

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2.1.6 Americans with Disabilities Act (ADA)

2.1.6.1 "Americans with Disabilities Act (ADA)" means a civil rights law that prohibits discrimination against Members with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.²

2.1.7 Appeal Process

2.1.7.1 "Appeal Process" means the procedure for handling, processing, collecting and tracking Member requests for a review of an adverse benefit determination which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.8 Area Agency

2.1.8.1 "Area Agency" means an entity established as a nonprofit corporation in the State of New Hampshire which is established by rules adopted by the Commissioner to provide services to developmentally disabled persons in the area as defined in RSA 171-A:2.

2.1.9 ASAM Level of Care

2.1.9.1 "ASAM Level of Care" means a standard nomenclature for describing the continuum of recovery-oriented addiction services. With the continuum, clinicians are able to conduct multidimensional assessments that explore individual risks and needs, and recommended ASAM Level of Care that matches intensity of treatment services to identified patient needs.

2.1.10 Assertive Community Treatment (ACT)

2.1.10.1 "Assertive Community Treatment (ACT)" means the evidence-based practice of delivering comprehensive and effective services to Members with SMI by a multidisciplinary team primarily in Member homes, communities, and other natural environments.

2.1.11 Auxiliary Aids

2.1.11.1 "Auxiliary Aids" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy, the benefits of programs or activities conducted by the MCO.

2.1.11.1.1 Such aids include readers, Braille materials, audio recordings, telephone handset amplifiers, telephones compatible

² The Americans with Disability Act National Network, "What is the Americans with Disabilities Act"

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with hearing aids, telecommunication devices for deaf persons (TDDs), interpreters, note takers, written materials, and other similar services and devices.

2.1.12 Behavioral Health Services

2.1.12.1 "Behavioral Health Services" means mental health and Substance Use Disorder services that are Covered Services under this Agreement.

2.1.13 [~~Amendment #7:~~] Intentionally Left Blank Behavioral Health Crisis Treatment Center (BHCTC)

~~2.1.13.1 [~~Amendment #7:~~] "Behavioral Health Crisis Treatment Center (BHCTC)" means a treatment service center that provides twenty-four (24) hours a day, seven (7) days a week intensive, short term stabilization treatment services for Members experiencing a mental health crisis, including those with co-occurring Substance Use Disorder.~~

~~2.1.13.2 [~~Amendment #7:~~] The BHCTC accepts Members for treatment on a voluntary basis who walk in, are transported by first responders, or as a stepdown treatment site post emergency department (ED) visit or inpatient psychiatric treatment site.~~

~~2.1.13.3 [~~Amendment #7:~~] The BHCTC delivers an array of services to de-escalate and stabilize Members at the intensity and for the duration necessary to quickly and successfully discharge, via specific after care plans, the Member back into the community or to a stop-down treatment site.~~

2.1.14 Bright Futures

2.1.14.1 "Bright Futures" means a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) that provides theory-based and evidence-driven guidance for all preventive care screenings and well-child visits.

2.1.15 Capitation Payment

2.1.15.1 "Capitation Payment" means the monthly payment by DHHS to the MCO for each Member enrolled in the MCO's plan for which the MCO provides Covered Services under this Agreement.

2.1.15.1.1 Capitation payments are made only for Medicaid-eligible Members and retained by the MCO for those Members. DHHS makes the payment regardless of whether the Member receives services during the period covered by the payment. [42 CFR 438.2]

2.1.16 Care Coordination

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2.1.16.1 [Amendment #2:] "Care Coordination" means the interaction with established local community-based providers of care, including Local Care Management Networks entities, to address the physical, behavioral health and psychosocial needs of Members.

2.1.17 Care Management

2.1.17.1 ""Care Management" means direct contact with a Member focused on the provision of various aspects of the Member's physical, behavioral health and needed supports that will enable the Member to achieve the best health outcomes.

2.1.18 Care Manager

2.1.18.1 [Amendment #2:] "Care Manager" means a qualified and trained individual who is hired directly by the MCO, a provider in the MCO's network (a "Participating Provider"), or a provider for a Local Care Management Network entity with which the MCO contracts who is primarily responsible for providing Care Coordination and Care Management services as defined by this Agreement.

2.1.19 Case Management

2.1.19.1 "Case Management" means services that assist Members in gaining access to needed waivers and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

2.1.20 Centers for Medicare & Medicaid Services (CMS)

2.1.20.1 "Centers for Medicare & Medicaid Services (CMS)" means the federal agency within the United States Department of Health and Human Services (HHS) with primary responsibility for the Medicaid and Medicare programs.

2.1.21 Children with Special Health Care Needs

2.1.21.1 "Children with Special Health Care Needs" means Members under age twenty-one (21) who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age.

2.1.21.1.1 This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with Neonatal Abstinence Syndrome (NAS); in high stress social environments/caregiver stress; receiving Family Centered Early

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Supports and Services, or participating in Special Medical Services or Partners in Health Services with a SED, I/DD or Substance Use Disorder diagnosis.

2.1.22 Children's Health Insurance Program (CHIP)

2.1.22.1 "Children's Health Insurance Program (CHIP)" means a program to provide health coverage to eligible children under Title XXI of the Social Security Act.

2.1.23 Choices for Independence (CFI)

2.1.23.1 "Choices for Independence (CFI)" means the Home and Community-Based Services (HCBS) 1915(c) waiver program that provides a system of Long Term Services and Supports (LTSS) to seniors and adults who are financially eligible for Medicaid and medically qualify for institutional level of care provided in nursing facilities.

2.1.23.2 The CFI waiver is also known as HCBS for the Elderly and Chronically Ill (HCBS-ECI). Long term care definitions are identified in RSA 151 E and He-E 801, and Covered Services are identified in He-E 801.

2.1.24 Chronic Condition

2.1.24.1 "Chronic Condition" means a physical or mental impairment or ailment of indefinite duration or frequent recurrence such as heart disease, stroke, cancer, diabetes, obesity, arthritis, mental illness or a Substance Use Disorder.

2.1.25 Clean Claim

2.1.25.1 ~~[Amendment #7:] [Amendment #6:]~~ "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a health plan's ~~State's~~ claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. [42 CFR 447.45(b)] ~~"Clean Claim" means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.~~

2.1.26 Cold Call Marketing

2.1.26.1 "Cold Call Marketing" means any unsolicited personal contact by the MCO or its designee, with a potential Member or a

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Member with another contracted MCO for the purposes of Marketing.
[42 CFR 438.104(a)]

2.1.27 Community Mental Health Services

2.1.27.1 "Community Mental Health Services" means mental health services provided by a Community Mental Health Program ("CMH Program") or Community Mental Health Provider ("CMH Provider") to eligible Members as defined under He-M 426.

2.1.28 Community Mental Health Program ("CMH Program")

2.1.28.1 "Community Mental Health Program ("CMH Program")", synonymous with Community Mental Health Center, means a program established and administered by the State of New Hampshire, city, town, or county, or a nonprofit corporation for the purpose of providing mental health services to the residents of the area and which minimally provides emergency, medical or psychiatric screening and evaluation, Case Management, and psychotherapy services, [RSA 135-C:2, IV] A CMH Program is authorized to deliver the comprehensive array of services described in He-M 426 and is designated to cover a region as described in He-M 425.

2.1.29 Community Mental Health Provider ("CMH Provider")

2.1.29.1 "Community Mental Health Provider ("CMH Provider")" means a Medicaid Provider of Community Mental Health Services that has been previously approved by the DHHS Commissioner to provide specific mental health services pursuant to He-M 426 [He-M 426.02: (g)]. The distinction between a CMH Program and a CMH Provider is that a CMH Provider offers a more limited range of services.

2.1.30 Comprehensive Assessment

2.1.30.1 "Comprehensive Assessment" means a person-centered assessment to help identify a Member's health condition, functional status, accessibility needs, strengths and supports, health care goals and other characteristics to inform whether a Member requires Care Management services and the level of services that should be provided.

2.1.31 Confidential Information

2.1.31.1 "Confidential Information" or "Confidential Data" means information that is exempt from disclosure to the public or other unauthorized persons under State or federal law. Confidential Information includes, but is not limited to, personal information (PI). See definition also listed in Exhibit K.

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2.1.32 Consumer Assessment of Health Care Providers and Systems (CAHPS®)

2.1.32.1 "Consumer Assessment of Health Care Providers and Systems (CAHPS®)" means a family of standardized survey instruments, including a Medicaid survey, used to measure Member experience of health care.

2.1.33 Continuity of Care

2.1.33.1 "Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through Member transitions between: facilities and home; facilities; Providers; service areas; managed care contractors; Marketplace, Medicaid fee-for-service (FFS) or private insurance and managed care arrangements. Continuity of Care occurs in a manner that prevents unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

2.1.34 Continuous Quality Improvement (CQI)

2.1.34.1 "Continuous Quality Improvement (CQI)" means the systematic process of identifying, describing, and analyzing strengths and weaknesses and then testing, implementing, learning from, and revising solutions.

2.1.35 Copayment

2.1.35.1 "Copayment" means a monetary amount that a Member pays directly to a Provider at the time a covered service is rendered.

2.1.36 Corrective Action Plan (CAP)

2.1.36.1 "Corrective Action Plan (CAP)" means a plan that the MCO completes and submits to DHHS to identify and respond to any issues and/or errors in instances where it fails to comply with DHHS requirements.

2.1.37 Covered Services

2.1.37.1 "Covered Services" means health care services as defined by DHHS and State and federal regulations and includes Medicaid State Plan services specified in this Agreement, In Lieu of Services, any Value-Added Services agreed to by the MCO in the Agreement, and services required to meet Mental Health Parity and Addiction Equity Act.

2.1.38 Entities [Amendment #2:] Designated Local Care Management Networks

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[Amendment #2:] "Designated Local Care Management Networks Entities" means Integrated Delivery Networks (IDNs) that have been certified as Designated Local Care Management Networks Entities by DHHS; Health Homes, if DHHS elects to implement Health Homes under the Medicaid State Plan Amendment authority; and other contracted entities capable of performing Local Care Management for a designated cohort of Members, as determined by DHHS.

2.1.39 Designated Receiving Facility

2.1.39.1 "Designated Receiving Facility" means a hospital-based psychiatric unit or a non-hospital-based residential treatment program designated by the Commissioner to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system as defined in He-M 405.

2.1.40 Dual-Eligible Members

2.1.40.1 "Dual-Eligible Members" means Members who are eligible for both Medicare and Medicaid.

2.1.41 Emergency Medical Condition

2.1.41.1 "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the Member (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]

2.1.42 Emergency Services

2.1.42.1 "Emergency Services" means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition. [42 CFR 438.114(a)]

2.1.43 Equal Access

2.1.43.1 "Equal Access" means all Members have the same access to all Providers and services.

2.1.44 Evidence-Based Supported Employment (EBSE)

2.1.44.1 "Evidence-Based Supported Employment (EBSE)" means the provision of vocational supports to Members following the Supported Employment Implementation Resource Kit developed by

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Dartmouth Medical School to promote successful competitive employment in the community.

2.1.45 Exclusion Lists

2.1.45.1 "Exclusion Lists" means HHS Office of the Inspector General's (OIG) List of Excluded Individuals/Entities; the System of Award Management; the Social Security Administration Death Master File; the list maintained by the Office of Foreign Assets Controls; and to the extent applicable, National Plan and Provider Enumeration System (NPPES).

2.1.46 External Quality Review (EQR)

2.1.46.1 "External Quality Review (EQR)" means the analysis and evaluation described in 42 CFR 438.350 by an External Quality Review Organization (EQRO) detailed in 42 CFR 438.42 of aggregated information on quality, timeliness, and access Covered Services that the MCO or its Subcontractors furnish to Medicaid recipients.

2.1.47 Family Planning Services

2.1.47.1 "Family Planning Services" means services available to Members by Participating or Non-Participating Providers without the need for a referral or Prior Authorization that include:

2.1.47.1.1 Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations, and sexually transmitted diseases;

2.1.47.1.2 Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases;

2.1.47.1.3 Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided;

2.1.47.1.4 Referral of Members to physicians or health agencies for consultation, examination, tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases, as indicated; and

2.1.47.1.5 Immunization services where medically indicated and linked to sexually transmitted diseases, including but not limited to Hepatitis B and Human papillomaviruses vaccine.

2.1.48 Federally Qualified Health Centers (FQHCs)

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2.1.48.1 "Federally Qualified Health Center (FQHC)" means a public or private non-profit health care organization that has been identified by the Health Resources and Services Administration (HRSA) and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.

2.1.49 Granite Advantage Members

2.1.49.1 "Granite Advantage Members" means Members who are covered under the NH Granite Advantage waiver, which includes individuals in the Medicaid new adult eligibility group, covered under Title XIX of the Social Security Act who are adults, aged nineteen (19) up to and including sixty-four (64) years, with incomes up to and including one hundred and thirty-eight percent (138%) of the federal poverty level (FPL) who are not pregnant, not eligible for Medicare and not enrolled in NH's Health Insurance Premium Payment (HIPP) program.

2.1.50 Grievance Process

2.1.50.1 "Grievance Process" means the procedure for addressing Member grievances and which is in compliance with 42 CFR 438 Subpart F and this Agreement.

2.1.51 Home and Community Based Services (HCBS)

2.1.51.1 "Home and Community Based Services (HCBS)" means the waiver of Sections 1902(a)(10) and 1915(c) of the Social Security Act, which permits the federal Medicaid funding of LTSS in non-institutional settings for Members who reside in the community or in certain community alternative residential settings, as an alternative to long term institutional services in a nursing facility or Intermediate Care Facility (ICF). This includes services provided under the HCBS-CFI waiver program, Developmental Disabilities (HCBS-DD) waiver program, Acquired Brain Disorders (HCBS-ABD) waiver program, and In Home Supports (HCBS-I) waiver program.

2.1.52 Hospital-Acquired Conditions and Provider Preventable Conditions

2.1.52.1 "Hospital-Acquired Conditions and Provider Preventable Conditions" means a condition that meets the following criteria: Is identified in the Medicaid State Plan; has been found by NH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Member; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a

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Member, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong Member.

2.1.53 In Lieu Of Services

2.1.53.1 An "In Lieu Of Service" means an alternative service or setting that DHHS has approved as medically appropriate and cost-effective substitute for a Covered Service or setting under the Medicaid State Plan.

2.1.53.2 [Amendment #10:] A Member cannot be required by the MCO to use the alternative service or setting. Beginning January 3, 2023, all Any In Lieu Of Services shall be reviewed for consideration and shall be authorized in accordance with federal regulations, as appropriate by DHHS, either via DHHS's issuance of prospective identification of approved In Lieu of Services or through an agreement reached between DHHS and the MCO. [42 CFR 438.3(e)(2)(i) - (iii); SMDL #23-001]

2.1.53.3 The utilization and actual cost of In Lieu Of Services shall be taken into account in developing the component of the capitation rates that represents the Medicaid State Plan Covered Services, unless a statute or regulation explicitly requires otherwise.

2.1.54 Incomplete Claim

2.1.54.1 "Incomplete Claim" means a claim that is denied for the purpose of obtaining additional information from the Provider.

2.1.55 Indian Health Care Provider (IHCP)

2.1.55.1 "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in the Indian Health Care Improvement Act (25 U.S.C. 1603). [42 CFR 438.14(a)]

2.1.56 Integrated Care

2.1.56.1 "Integrated Care" means the systematic coordination of mental health, Substance Use Disorder, and primary care services to effectively care for people with multiple health care needs.³

2.1.57 Integrated Delivery Network (IDN)

2.1.57.1 "Integrated Delivery Network" means a regionally-based network of physical and behavioral health providers and/or social

³ SAMHSA-HRSA Center for Integrated Solutions, "What is Integrated Care?"

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service organizations that participate in the NH Building Capacity for Transformation Section 1115 Waiver or are otherwise determined by DHHS to be an Integrated Delivery Network.

2.1.57.2 [Amendment #8:] Effective December 31, 2020, the phrase "Integrated Delivery Network" and acronym "IDN" is retained as informational due to the expiration of the NH Building Capacity for Transformation Section 1115 Waiver.

2.1.58 Limited English Proficiency (LEP)

2.1.58.1 "Limited English Proficiency (LEP)" means a Member's primary language is not English and the Member may have limited ability to read, write, speak or understand English.

2.1.59 Local Care Management

2.1.59.1 "Local Care Management" means the MCO engages in real-time, high-touch, or a supportive in-person Member engagement strategy used for building relationships with Members that includes consistent follow-up with Providers and Members to assure that selected Members are making progress with their care plans.

2.1.60 Long Term Services and Supports (LTSS)

2.1.60.1 "Long Term Services and Supports (LTSS)" means nursing facility services, all four of NH's Home and Community Based Care waivers, and services provided to children and families through the Division for Children, Youth and Families (DCYF).

2.1.61 Managed Care Information System (MCIS)

2.1.61.1 "Managed Care Information System (MCIS)" means a comprehensive, automated and integrated system that: collects, analyzes, integrates, and reports data [42 CFR 438.242(a)]; provides information on areas, including but not limited to utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility [42 CFR 438.242(a)]; collects and maintains data on Members and Providers, as specified in this Agreement and on all services furnished to Members, through an encounter data system [42 CFR 438.242(b)(2)]; is capable of meeting the requirements listed throughout this Agreement; and is capable of providing all of the data and information necessary for DHHS to meet State and federal Medicaid reporting and information regulations.

2.1.62 Managed Care Organization (MCO)

2.1.62.1 "Managed Care Organization (MCO)" means an entity that has a certificate of authority from the NH Insurance Department

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(NHID) and who contracts with DHHS under a comprehensive risk Agreement to provide health care services to eligible Members under the MCM program.

2.1.63 Marketing

2.1.63.1 "Marketing" means any communication from the MCO to a potential Member, or Member who is not enrolled in that MCO, that can reasonably be interpreted as intended to influence the Member to enroll with the MCO or to either not enroll, or disenroll from another DHHS contracted MCO. [42 CFR 438.104(a)]

2.1.64 Marketing Materials

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the MCO that can be reasonably interpreted as intended as Marketing to potential Members. [42 CFR 438.104(a)(ii)]

2.1.65 MCO Alternative Payment Model (APM) Implementation Plan

2.1.65.1 "MCO Alternative Payment Model (APM) Implementation Plan" means the MCO's plan for meeting the APM requirements described in this Agreement. The MCO APM Implementation Plan shall be reviewed and approved by DHHS.

2.1.66 MCO Data Certification

2.1.66.1 "MCO Data Certification" means data submitted to DHHS and certified by one of the following:

2.1.66.1.1 The MCO's Chief Executive Officer (CEO);

2.1.66.1.2 The MCO's Chief Financial Officer (CFO); or

2.1.66.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO.

2.1.67 MCO Formulary

2.1.67.1 "MCO Formulary" means the list of prescription drugs covered by the MCO and the tier on which each medication is placed, in compliance with the DHHS-developed Preferred Drug List (PDL) and 42 CFR 438.10(i).

2.1.68 MCO Quality Assessment and Performance Improvement (QAPI) Program

2.1.68.1 "MCO Quality Assessment and Performance Improvement (QAPI) Program" means an ongoing and comprehensive program for the services the MCO furnishes to Members consistent with the requirements of this Agreement and

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federal requirements for the QAPI program. [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)]

2.1.69 MCO Utilization Management Program

2.1.69.1 "MCO Utilization Management Program" means a program developed, operated, and maintained by the MCO that meets the criteria contained in this Agreement related to Utilization Management. The MCO Utilization Management Program shall include defined structures, policies, and procedures for Utilization Management.

2.1.70 Medicaid Director

2.1.70.1 "Medicaid Director" means the State Medicaid Director of NH DHHS.

2.1.71 Medicaid Management Information System (MMIS)

2.1.71.1 "Medicaid Management Information System (MMIS)" as defined by the CMS.gov glossary is: a CMS approved system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, Surveillance and Utilization Review Subsystem (SURS), Management and Administrative Reporting System (MARS), and potentially encounter processing.

2.1.72 Medicaid State Plan

2.1.72.1 "Medicaid State Plan" means an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state.

2.1.73 Medical Loss Ratio (MLR)

2.1.73.1 "Medical Loss Ratio (MLR)" means the proportion of premium revenues spent on clinical services and quality improvement, calculated in compliance with the terms of this Agreement and with all federal standards, including 42 CFR 438.8.

2.1.74 Medically Necessary

2.1.74.1 Per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Members under twenty-one (21) years of age,

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"Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

2.1.74.2 For Members twenty-one (21) years of age and older, "Medically Necessary" means services that a licensed Provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

2.1.74.2.1 Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the Member's illness, injury, disease, or its symptoms;

2.1.74.2.2 Not primarily for the convenience of the Member or the Member's family, caregiver, or health care Provider;

2.1.74.2.3 No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the Member's illness, injury, disease, or its symptoms; and

2.1.74.2.4 Not experimental, investigative, cosmetic, or duplicative in nature [He-W 530.01(e)].

2.1.75 Medication Assisted Treatment (MAT)

2.1.75.1 "Medication Assisted Treatment (MAT)" means the use of medications in combination with counseling and behavioral therapies for the treatment of Substance Use Disorder.⁴

2.1.76 Member

2.1.76.1 "Member" means an individual who is enrolled in managed care through an MCO having an Agreement with DHHS. [42 CFR 438.10(a)]

2.1.77 Member Advisory Board

2.1.77.1 "Member Advisory Board" means a group of Members that represents the Member population, established and facilitated by the MCO. The Member Advisory Board shall adhere to the requirements set forth in this Agreement.

⁴ SAHMSA-HRSA Center for Integrated Health Solutions, "Medication Assisted Treatment"

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2.1.78 Member Encounter Data (Encounter Data)

2.1.78.1 "Member Encounter Data ("Encounter Data")" means the information relating to the receipt of any item(s) or service(s) by a Member, under this Agreement, between DHHS and an MCO that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818.

2.1.79 Member Handbook

2.1.79.1 "Member Handbook" means a handbook based upon the model Member Handbook developed by DHHS and published by the MCO that enables the Member to understand how to effectively use the MCM program in accordance with this Agreement and 42 CFR 438.10(g).

2.1.80 National Committee for Quality Assurance (NCQA)

2.1.80.1 "National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

2.1.81 NCQA Health Plan Accreditation

"NCQA Health Plan Accreditation" means MCO accreditation, including the Medicaid module obtained from the NCQA, based on an assessment of clinical performance and consumer experience.

2.1.82 Neonatal Abstinence Syndrome (NAS)

2.1.82.1 "Neonatal Abstinence Syndrome (NAS)" means a constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids.⁵

2.1.83 Non-Emergency Medical Transportation (NEMT)

2.1.83.1 "Non-Emergency Medical Transportation (NEMT)" means transportation services arranged by the MCO and provided free of charge to Members who are unable to pay for the cost of transportation to Provider offices and facilities for Medically Necessary care and services covered by the Medicaid State Plan, regardless of whether those Medically Necessary services are covered by the MCO.

2.1.84 Non-Participating Provider

2.1.84.1 "Non-Participating Provider" means a person, health care Provider, practitioner, facility or entity acting within their scope of

⁵ CMCS Informational Bulletin, "Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants," Centers for Medicare and Medicaid Services, June 11, 2018

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practice or licensure, that does not have a written Agreement with the MCO to participate in the MCO's Provider network, but provides health care services to Members under appropriate scenarios (e.g., a referral approved by the MCO).

2.1.85 Non-Symptomatic Office Visits

2.1.85.1 "Non-Symptomatic Office Visits" means preventive care office visits available from the Member's Primary Care Provider (PCP) or another Provider within forty-five (45) calendar days of a request for the visit. Non-Symptomatic Office Visits may include, but are not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

2.1.86 Non-Urgent, Symptomatic Office Visits

2.1.86.1 "Non-Urgent, Symptomatic Office Visits" means routine care office visits available from the Member's PCP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of medical signs or symptoms not requiring immediate attention, but that require monitoring.

2.1.87 Ongoing Special Condition

2.1.87.1 "Ongoing Special Condition" means, in the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm; in the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; in the case of pregnancy, pregnancy from the start of the second trimester; in the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

2.1.88 Overpayments

2.1.88.1 "Overpayments" means any amount received to which the Provider is not entitled. An overpayment includes payment that should not have been made and payments made in excess of the appropriate amount.

2.1.89 Participating Provider

2.1.89.1 "Participating Provider" means a person, health care Provider, practitioner, facility, or entity, acting within the scope of practice and licensure, and who is under a written contract with the

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MCO to provide services to Members under the terms of this Agreement.

2.1.90 Peer Recovery Program

2.1.90.1 "Peer Recovery Program" means a program that is accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or another accrediting body approved by DHHS, is under contract with DHHS's contracted facilitating organization, or is under contract with DHHS's Bureau of Drug and Alcohol Services to provide Peer Recovery Support Services (PRSS).

2.1.91 Performance Improvement Project (PIP)

2.1.91.1 "Performance Improvement Project (PIP)" means an initiative included in the QAPI program that focuses on clinical and non-clinical areas. A PIP shall be developed in consultation with the EQRO. [42 CFR 438.330(b)(1); 42 CFR 438.330(d)(1); 42 CFR 438.330(a)(2)].

2.1.92 Physician Group

2.1.92.1 "Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its Members. An individual practice association is a Physician Group only if it is composed of individual physicians and has no Subcontracts with Physician Groups.

2.1.93 Physician Incentive Plan

2.1.93.1 "Physician Incentive Plan" means any compensation arrangement between the MCO and Providers that apply to federal regulations found at 42 CFR 422.208 and 42 CFR 422.210, as applicable to Medicaid managed care on the basis of 42 CFR 438.3(i).

2.1.94 Post-Stabilization Services

2.1.94.1 "Post-Stabilization Services" means contracted services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition. [42 CFR 438.114; 422.113]

2.1.95 Practice Guidelines

2.1.95.1 "Practice Guidelines" means evidence-based clinical guidelines adopted by the MCO that are in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines shall be based on valid and reasonable

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clinical evidence or a consensus of Providers in the particular field, shall consider the needs of Members, be adopted in consultation with Participating Providers, and be reviewed and updated periodically as appropriate.

2.1.96 Prescription Drug Monitoring Program (PDMP)

2.1.96.1 "Prescription Drug Monitoring Program (PDMP)" means the program operated by the NH Office of Professional Licensure and Certification that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances in NH.

2.1.97 Primary Care Provider (PCP)

2.1.97.1 "Primary Care Provider (PCP)" means a Participating Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the Continuity of Member Care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists (OB/GYNs), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All federal requirements applicable to primary care physicians shall also be applicable to PCPs as the term is used in this Agreement.

2.1.98 Prior Authorization

2.1.98.1 "Prior Authorization" means the process by which DHHS, the MCO, or another MCO participating in the MCM program, whichever is applicable, authorizes, in advance, the delivery of Covered Services based on factors, including but not limited to medical necessity, cost-effectiveness, and compliance with this Agreement.

2.1.99 Priority Population

2.1.99.1 "Priority Population" means a population that is most likely to have Care Management needs and be able to benefit from Care Management. The following groups are considered Priority Populations under this Agreement: Adults and Children with Special Health Care Needs, including, but not limited to, Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis, or with chronic pain; Members receiving services under HCBS waivers; Members identified as those with rising risk; individuals with

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high unmet resource needs; mothers of babies born with NAS; infants with NAS; pregnant women with Substance Use Disorder; intravenous drug users, including Members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use; individuals who have been in the ED for an overdose event in the last twelve (12) months; recently incarcerated individuals; individuals who have a suicide attempt in the last twelve (12) months and other Priority Populations as determined by the MCO and/or DHHS.

2.1.100 Program Start Date

2.1.100.1 "Program Start Date" means the date when the MCO is responsible for coverage of services to its Members in the MCM program, contingent upon Agreement approval by the Governor and Executive Council and DHHS's determination of successful completion of the Readiness Review period.

2.1.101 Provider

2.1.101.1 "Provider" means an individual medical, behavioral or social service professional, hospital, skilled nursing facility (SNF), other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

2.1.102 Provider Directory

2.1.102.1 "Provider Directory" means information on the MCO's Participating Providers for each of the Provider types covered under this Agreement, available in electronic form and paper form upon request to the Member in accordance with 42 CFR 438.10 and the terms of this Agreement.

2.1.103 Psychiatric Boarding

2.1.103.1 "Psychiatric Boarding" means a Member's continued physical presence in an emergency room or another temporary location after either completion of an Involuntary Emergency Admission (IEA) application, revocation of a conditional discharge, or commitment to New Hampshire Hospital or other designated receiving facility by a Court.

2.1.104 Qualified Bilingual/Multilingual Staff

2.1.104.1 "Qualified Bilingual/Multilingual Staff" means an employee of the MCO who is designated by the MCO to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the MCO that he or she is proficient in speaking and understanding spoken English and at

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least one (1) other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and is able to effectively, accurately, and impartially communicate directly with Members with LEP in their primary languages.

2.1.105 Qualified Interpreter for a Member with a Disability

2.1.105.1 "Qualified Interpreter for a Member with a Disability" means an interpreter who, via a remote interpreting service or an on-site appearance, adheres to generally accepted interpreter ethics principles, including Member confidentiality; and is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology:

2.1.105.2 Qualified interpreters can include, for example, sign language interpreters, oral transliterators (employees who represent or spell in the characters of another alphabet), and cued language transliterators (employees who represent or spell by using a small number of handshapes).

2.1.106 Qualified Interpreter for a Member with LEP

2.1.106.1 "Qualified Interpreter for a Member with LEP" means an interpreter who, via a remote interpreting service or an on-site appearance adheres to generally accepted interpreter ethics principles, including Member confidentiality; has demonstrated proficiency in speaking and understanding spoken English and at least one (1) other spoken language; and is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

2.1.107 Qualified Translator

2.1.107.1 "Qualified Translator" means a translator who adheres to generally accepted translator ethics principles, including Member confidentiality; has demonstrated proficiency in writing and understanding written English and at least one (1) other written language; and is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. [45 CFR 92.4, 92.201(d)-(e)]

2.1.108 Qualifying APM

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2.1.108.1 "Qualifying APM" means an APM approved by DHHS as consistent with the standards specified in this Agreement and in any subsequent DHHS guidance, including the DHHS Medicaid APM Strategy.

2.1.109 Recovery

2.1.109.1 "Recovery" means a process of change through which Members improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and Recovery support services for all populations.⁶

2.1.110 Referral Provider

2.1.110.1 "Referral Provider" means a Provider, who is not the Member's PCP, to whom a Member is referred for Covered Services.

2.1.111 Risk Scoring and Stratification

2.1.111.1 "Risk Scoring and Stratification" means the methodology to identify Members who are part of a Priority Population for Care Management and who should receive a Comprehensive Assessment. The MCO shall provide protocols to DHHS for review and approval on how Members are stratified by severity and risk level including details regarding the algorithm and data sources used to identify eligible Member for Care Management.

2.1.112 Rural Health Clinic (RHC)

2.1.112.1 "Rural Health Clinic (RHC)" means a clinic located in an area designated by DHHS as rural, located in a federally designated medically underserved area, or has an insufficient number of physicians, which meets the requirements under 42 CFR 491.

2.1.113 Second Opinion

2.1.113.1 "Second Opinion" means the opinion of a qualified health care professional within the Provider network, or the opinion of a Non-Participating Provider with whom the MCO has permitted the Member to consult, at no cost to the Member. [42 CFR 438.206(b)(3)]

2.1.114 Social Determinants of Health

2.1.114 "Social Determinants of Health" means a wide range of factors known to have an impact on healthcare, ranging from socioeconomic status, education and employment, to one's physical environment and access to healthcare.

⁶ SAMHSA, "Recovery and Recovery Support"

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2.1.115 State

2.1.115.1 The "State" means the State of New Hampshire and any of its agencies.

2.1.116 Subcontract

2.1.116.1 "Subcontract" means any separate contract or contract between the MCO and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the MCO is obligated to perform pursuant to this Agreement.

2.1.117 Subcontractor

2.1.117.1 "Subcontractor" means a person or entity that is delegated by the MCO to perform an administrative function or service on behalf of the MCO that directly or indirectly relates to the performance of all or a portion of the duties or obligations under this Agreement. A Subcontractor does not include a Participating Provider.

2.1.118 Substance Use Disorder

2.1.118.1 "Substance Use Disorder" means a cluster of symptoms meeting the criteria for Substance Use Disorder as set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th edition (2013), as described in He-W 513.02.

2.1.119 Substance Use Disorder Provider

2.1.119.1 "Substance Use Disorder Provider" means all Substance Use Disorder treatment and Recovery support service Providers as described in He-W 513.04.

2.1.120 Term

2.1.120.1 "Term" means the duration of this Agreement.

2.1.121 Third Party Liability (TPL)

2.1.121.1 "Third Party Liability (TPL)" means the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid State Plan.

2.1.121.2 By law, all other available third party resources shall meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

2.1.121.3 States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid State Plan.

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2.1.122 Transitional Care Management

2.1.122.1 "Transitional Care Management" means the responsibility of the MCO to manage transitions of care for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

2.1.122.2 The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

2.1.123 Transitional Health Care

2.1.123.1 "Transitional Health Care" means care that is available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

2.1.124 Transitional Home Care

2.1.124.1 "Transitional Home Care" means care that is available with a home care nurse, a licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or specialty care Provider or as part of the discharge plan.

2.1.125 Trauma Informed Care

2.1.125.1 "Trauma Informed Care" means a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for Recovery; recognizes the signs and symptoms of trauma in Members, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.⁷

2.1.126 Urgent, Symptomatic Office Visits

2.1.126.1 "Urgent, Symptomatic Office Visits" means office visits, available from the Member's PCP or another Provider within forty-eight (48) hours, for the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

⁷ SAMHSA, "Trauma Informed Approach and Trauma-Specific Interventions"

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2.1.127 Utilization Management

2.1.127.1 "Utilization Management" means the criteria of evaluating the necessity, appropriateness, and efficiency of Covered Services against established guidelines and procedures.

2.1.128 Value-Added Services

2.1.128.1 "Value-Added Services" means services not included in the Medicaid State Plan that the MCO elects to purchase and provide to Members at the MCO's discretion and expense to improve health and reduce costs. Value-Added Services are not included in capitation rate calculations.

2.1.129 Willing Provider

2.1.129.1 [Amendment #8:] "Willing Provider" means a Provider credentialed as a qualified treatment provider according to the requirements of DHHS and the MCO, who agrees to render services as authorized by the MCO and to comply with the terms of the MCO's Provider Agreement, including rates and policy manual.

2.2 Acronym List

- 2.2.1 AAP means American Academy of Pediatrics.
- 2.2.2 ABD means Acquired Brain Disorder.
- 2.2.3 ACT means Assertive Community Treatment.
- 2.2.4 ADA means Americans with Disabilities Act.
- 2.2.5 ADL means Activities of Daily Living.
- 2.2.6 ADT means Admission, Discharge and Transfer.
- 2.2.7 AIDS means Acquired Immune Deficiency Syndrome.
- 2.2.8 ANSA means Adult Needs and Strengths Assessment.
- 2.2.9 APM means Alternative Payment Model.
- 2.2.10 ARNP means Advanced Registered Nurse Practitioner.
- 2.2.11 ASAM means American Society of Addiction Medicine.
- 2.2.12 ASC means Accredited Standards Committee.
- 2.2.13 ASFRA means Assisted Suicide Funding Restriction Act.
- 2.2.14 ASL means American Sign Language.
- 2.2.15 BCPP means Breast and Cervical Cancer Program.

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- 2.2.16** [Amendment #7]–~~BHCTC means Behavioral Health Crisis Treatment Center.~~ Intentionally Left Blank.
- 2.2.17** CAHPS means Consumer Assessment of Healthcare Providers and Systems.
- 2.2.18** CANS means Child and Adolescent Needs and Strengths Assessment.
- 2.2.19** CAP means Corrective Action Plan.
- 2.2.20** CAPRSS means Council on Accreditation of Peer Recovery Support Services.
- 2.2.21** CARC means Claim Adjustment Reason Code.
- 2.2.22** CDT means Code on Dental Procedures and Nomenclature.
- 2.2.23** CEO means Chief Executive Officer.
- 2.2.24** CFI means Choices for Independence.
- 2.2.25** CFO means Chief Financial Officer.
- 2.2.26** CHIP means Children’s Health Insurance Program.
- 2.2.27** CHIS means Comprehensive Health Care Information System.
- 2.2.28** CMH means Community Mental Health.
- 2.2.29** CMO means Chief Medical Officer.
- 2.2.30** CMR means Comprehensive Medication Review.
- 2.2.31** CMS means Centers for Medicare & Medicaid Services.
- 2.2.32** COB means Coordination of Benefits.
- 2.2.33** COBA means Coordination of Benefits Agreement.
- 2.2.34** CPT means Current Procedural Terminology.
- 2.2.35** CQI means Continuous Quality Improvement.
- 2.2.36** DBT means Dialectical Behavioral Therapy.
- 2.2.37** DCYF means New Hampshire Division for Children, Youth and Families.
- 2.2.38** DD means Developmental Disability.
- 2.2.39** DHHS means New Hampshire Department of Health and Human Services.
- 2.2.40** DME means Durable Medical Equipment.
- 2.2.41** DOB means Date of Birth.

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- 2.2.42 DOD means Date of Death.
- 2.2.43 DOJ means (New Hampshire or United States) Department of Justice.
- 2.2.44 DRA means Deficit Reduction Act.
- 2.2.45 DSM means Diagnostic and Statistical Manual of Mental Disorders.
- 2.2.46 DSRIP means The New Hampshire Delivery System Reform Incentive Payment Program.
- 2.2.47 DUR means Drug Utilization Review.
- 2.2.48 EBSE means Evidence-Based Supported Employment.
- 2.2.49 ECI means Elderly and Chronically Ill.
- 2.2.50 ED means Emergency Department.
- 2.2.51 EDI means Electronic Data Interchange.
- 2.2.52 EFT means Electronic Funds Transfer.
- 2.2.53 EOB means Explanation of Benefits.
- 2.2.54 EPSDT means Early and Periodic Screening, Diagnostic and Treatment.
- 2.2.55 EQR means External Quality Review.
- 2.2.56 EQRO means External Quality Review Organization.
- 2.2.57 ERISA means Employees Retirement Income Security Act of 1974.
- 2.2.58 EST means Eastern Standard Time.
- 2.2.59 ETL means Extract, Transformation and Load.
- 2.2.60 FAR means Federal Acquisition Regulation.
- 2.2.61 FCA means False Claims Act.
- 2.2.62 FDA means Food and Drug Administration for the United States Department of Health and Human Services.
- 2.2.63 FFATA means Federal Funding Accountability & Transparency Act.
- 2.2.64 FFS means Fee-for-Service.
- 2.2.65 FPL means Federal Poverty Level.
- 2.2.66 FQHC means Federally Qualified Health Center.
- 2.2.67 HCBS means Home and Community Based Services.
- 2.2.68 HCBS-I means Home and Community Based Services In Home Supports.

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- 2.2.69 HCPCS means Health Care Common Procedure Coding System.
- 2.2.70 HHS means United States Department of Health and Human Services.
- 2.2.71 HIPAA means Health Insurance Portability and Accountability Act.
- 2.2.72 HIPP means Health Insurance Premium Payment.
- 2.2.73 HITECH means Health Information Technology for Economic and Clinical Health Act of 2009.
- 2.2.74 HIV means Human Immunodeficiency Virus.
- 2.2.75 HMO means health maintenance organization.
- 2.2.76 HRSA means Health Resources and Services Administration for the United States Department of Health and Human Services.
- 2.2.77 I/T/U means Indian Tribe, Tribal Organization, or Urban Indian Organization.
- 2.2.78 IADL means Instrumental Activities of Daily Living.
- 2.2.79 IBNR means Incurred But Not Reported.
- 2.2.80 ICF means Intermediate Care Facility.
- 2.2.81 ID means Intellectual Disabilities.
- 2.2.82 IDN means Integrated Delivery Network.
- 2.2.83 IEA means Involuntary Emergency Admission.
- 2.2.84 IHCP means Indian Health Care Provider.
- 2.2.85 IHS means Indian Health Service.
- 2.2.86 IMD means Institution for Mental Disease.
- 2.2.87 IVR means Interactive Voice Response.
- 2.2.88 LEP means Limited English Proficiency.
- 2.2.89 LTSS means Long-Term Services and Supports.
- 2.2.90 MACRA means Medicare Access and CHIP Reauthorization Act of 2015.
- 2.2.91 MAT means Medication Assisted Treatment.
- 2.2.92 MCIS means Managed Care Information System.
- 2.2.93 MCM means Medicaid Care Management.
- 2.2.94 MCO means Managed Care Organization.
- 2.2.95 MED means Morphine Equivalent Dosing.

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- 2.2.96 MFCU means New Hampshire Medicaid Fraud Control Unit.
- 2.2.97 MLADCs means Masters Licensed Alcohol and Drug Counselors.
- 2.2.98 MLR means Medical Loss Ratio.
- 2.2.99 MMIS means Medicaid Management Information System.
- 2.2.100 NAS means Neonatal Abstinence Syndrome.
- 2.2.101 NCPDP means National Council for Prescription Drug Programs.
- 2.2.102 NCQA means National Committee for Quality Assurance.
- 2.2.103 NEMT means Non-Emergency Medical Transportation.
- 2.2.104 NH means New Hampshire.
- 2.2.105 NHID means New Hampshire Insurance Department.
- 2.2.106 NPI means National Provider Identifier.
- 2.2.107 NPPES means National Plan and Provider Enumeration System.
- 2.2.108 OB/GYN means Obstetrics/Gynecology or Obstetricians/Gynecologists.
- 2.2.109 OIG means Office of the Inspector General for the United States Department of Health and Human Services.
- 2.2.110 OTP means Opioid Treatment Program.
- 2.2.111 PBM means Pharmacy Benefits Manager.
- 2.2.112 PCA means Personal Care Attendant.
- 2.2.113 PCP means Primary Care Provider.
- 2.2.114 PDL means Preferred Drug List.
- 2.2.115 PDMP means Prescription Drug Monitoring Program.
- 2.2.116 PHI means Protected Health Information.
- 2.2.117 PI means Personal Information.
- 2.2.118 PIP means Performance Improvement Project.
- 2.2.119 POS means Point of Service.
- 2.2.120 PRSS means Peer Recovery Support Services.
- 2.2.121 QAPI means Quality Assessment and Performance Improvement.
- 2.2.122 QOS means Quality of Service.
- 2.2.123 RARC means Reason and Remark Codes.

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- 2.2.124 RFP means Request for Proposal.
- 2.2.125 RHC means Rural Health Clinic.
- 2.2.126 SAMHSA means Substance Abuse and Mental Health Services Administration for the United States Department of Health and Human Services.
- 2.2.127 SBIRT means Screening, Brief Intervention, and Referral to Treatment.
- 2.2.128 SED means Serious Emotional Disturbance.
- 2.2.129 SHIP means State's Health Insurance Assistance Program.
- 2.2.130 SIU means Special Investigations Unit.
- 2.2.131 SMART means Specific, Measurable, Attainable, Realistic, and Time Relevant.
- 2.2.132 SMDL means State Medicaid Director Letter.
- 2.2.133 SMI means Severe Mental Illness.
- 2.2.134 SNF means Skilled Nursing Facility.
- 2.2.135 SPMI means Severe or Persistent Mental Illness.
- 2.2.136 SSADMf means Social Security Administration Death Master File.
- 2.2.137 SSAE means Statement on Standards for Attestation Engagements.
- 2.2.138 SSI means Supplemental Security Income.
- 2.2.139 SSN means Social Security Number.
- 2.2.140 TAP means Technical Assistance Publication.
- 2.2.141 TDD means Telecommunication Device for Deaf Persons.
- 2.2.142 TPL means Third Party Liability.
- 2.2.143 TTY means Teletypewriter.
- 2.2.144 UAT means User Acceptance Testing.
- 2.2.145 UDS means Urine Drug Screenings.
- 2.2.146 VA means United States Department of Veterans Affairs.

3 GENERAL TERMS AND CONDITIONS

3.1 Program Management and Planning

3.1.1 General

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3.1.1.1 The MCO shall provide a comprehensive risk-based, capitated program for providing health care services to Members enrolled in the MCM program and who are enrolled in the MCO.

3.1.1.2 The MCO shall provide for all aspects of administrating and managing such program and shall meet all service and delivery timelines and milestones specified by this Agreement, applicable law or regulation incorporated directly or indirectly herein, or the MCM program.

3.1.2 Representation and Warranties

3.1.2.1 The MCO represents and warrants that it shall fulfill all obligations under this Agreement and meet the specifications as described in the Agreement during the Term, including any subsequently negotiated, and mutually agreed upon, specifications.

3.1.2.2 The MCO acknowledges that, in being awarded this Agreement, DHHS has relied upon all representations and warrants made by the MCO in its response to the DHHS Request for Proposal (RFP) attached hereto as Exhibit M, including any addenda, with respect to delivery of Medicaid managed care services and affirms all representations made therein.

3.1.2.3 The MCO represents and warrants that it shall comply with all of the material submitted to, and approved by DHHS as part of its Readiness Review. Any material changes to such approved materials or newly developed materials require prior written approval by DHHS before implementation.

3.1.2.4 The MCO shall not take advantage of any errors and/or omissions in the RFP or the resulting Agreement and amendments.

3.1.2.4.1 The MCO shall promptly notify DHHS of any such errors and/or omissions that are discovered.

3.1.2.5 This Agreement shall be signed and dated by all parties, and is contingent upon approval by Governor and Executive Council.

3.1.3 Program Management Plan

3.1.3.1 The MCO shall develop and submit a Program Management Plan for DHHS's review and approval.

3.1.3.2 The MCO shall provide the initial Program Management Plan to DHHS for review and approval at the beginning of the Readiness Review period; in future years, any modifications to the Program Management Plan shall be presented for prior approval to

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DHHS at least sixty (60) calendar days prior to the coverage year. The Program Management Plan shall:

3.1.3.2.1 Elaborate on the general concepts outlined in the MCO's Proposal and the section headings of the Agreement;

3.1.3.2.2 Describe how the MCO shall operate in NH by outlining management processes such as workflow, overall systems as detailed in the section headings of Agreement, evaluation of performance, and key operating premises for delivering efficiencies and satisfaction as they relate to Member and Provider experiences;

3.1.3.2.3 Describe how the MCO shall ensure timely notification to DHHS regarding:

3.1.3.2.3.1. Expected or unexpected interruptions or changes that impact MCO policy, practice, operations, Members or Providers,

3.1.3.2.3.2. Correspondence received from DHHS on emergent issues and non-emergent issues; and

3.1.3.2.4 Outline the MCO integrated organizational structure including NH-based resources and its support from its parent company, affiliates, or Subcontractors.

3.1.3.3 On an annual basis, the MCO shall submit to DHHS either a certification of "no change" to the Program Management Plan or a revised Program Management Plan together with a redline that reflects the changes made to the Program Management Plan since the last submission.

3.1.4 Key Personnel Contact List

3.1.4.1 The MCO shall submit a Key Personnel Contact List to DHHS that includes the positions and associated information indicated in Section 3.15.1 (Key Personnel) of this Agreement at least sixty (60) calendar days prior to the scheduled start date of the MCM program.

3.1.4.2 Thereafter, the MCO shall submit an updated Contact List immediately upon any Key Personnel staff changes.

3.2 Agreement Elements

3.2.1 The Agreement between the parties shall consist of the following:

3.2.1.1 General Provisions, Form Number P-37

3.2.1.2 Exhibit A: Scope of Services.

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- 3.2.1.3 Exhibit B: Method and Conditions Precedent to Payment
- 3.2.1.4 Exhibit C: Special Provisions
- 3.2.1.5 Exhibit C-1: Revisions to General Provisions
- 3.2.1.6 Exhibit D: Certification Regarding Drug Free Workplace Requirements
- 3.2.1.7 Exhibit E: Certification Regarding Lobbying
- 3.2.1.8 Exhibit F: Certification Regarding Debarment, Suspension, and Other Responsibility Matters
- 3.2.1.9 Exhibit G: Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections
- 3.2.1.10 Exhibit H: Certification Regarding Environmental Tobacco Smoke
- 3.2.1.11 Exhibit I: Health Insurance Portability Act Business Associate
- 3.2.1.12 Exhibit J: Certification Regarding Federal Funding Accountability & Transparency Act (FFATA) Compliance.
- 3.2.1.13 Exhibit K: DHHS Information Security Requirements.
- 3.2.1.14 Exhibit L: MCO Implementation Plan
- 3.2.1.15 Exhibit M: MCO Proposal submitted in response to RFP-2019-OMS-02-MANAG, by reference.
- 3.2.1.16 Exhibit N: Liquidated Damages Matrix
- 3.2.1.17 Exhibit O: Quality and Oversight Reporting Requirements
- 3.2.1.18 Exhibit P: MCO Program Oversight Plan

3.3 Conflicts Between Documents

3.3.1 In the event of any conflict or contradiction between or among the documents which comprise the Agreement, as listed in Section 3.2 (Agreement Elements) above, the documents shall control in the order of precedence as follows:

- 3.3.1.1 First: P-37, Exhibit A Scope of Services, Exhibit B Method and Conditions Precedent to Payment, Exhibit C Special Provisions and Exhibit C-1 Revisions to General Provisions, Exhibit N Liquidated Damages Matrix, Exhibit O Quality and Oversight Reporting Requirements

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3.3.1.2 Second: Exhibit I Health Insurance Portability Act Business Associate and Exhibit K DHHS Information Security Requirements

3.3.1.3 Third: Exhibits D through H, Exhibit J, and Exhibit L, Exhibit P, Exhibit M.

3.4 Delegation of Authority

3.4.1 Whenever, by any provision of this Agreement, any right, power, or duty is imposed or conferred on DHHS, the right, power, or duty so imposed or conferred is possessed and exercised by the Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of the DHHS and NHID.

3.5 Authority of the New Hampshire Insurance Department

3.5.1 Pursuant to this Agreement and under the laws and rules of the State, the NHID shall have authority to regulate and oversee the licensing requirements of the MCO to operate as a health maintenance organization (HMO) in the State of New Hampshire.

3.5.2 The MCO is subject to all applicable laws and rules (and as subsequently amended) including but not limited to RSA 420-B; Managed Care Law and Rules RSA 420-J; and Admin Rules 2700; compliance with Bulletin INSNO. 12-015-AB, and further updates made by the NHID; and the NH Comprehensive Health Care Information System (CHIS) data reporting submission under NHID rules/bulletins.

3.6 Time of the Essence

3.6.1 In consideration of the need to ensure uninterrupted and continuous services under the MCM program, time is of the essence in the performance of the MCO's obligations under the Agreement.

3.7 CMS Approval of Agreement and Any Amendments

3.7.1 This Agreement and the implementation of amendments, modifications, and changes to this Agreement are subject to and contingent upon the approval of CMS.

3.7.2 This Agreement submission shall be considered complete for CMS's approval if:

3.7.2.1 All pages, appendices, attachments, etc. were submitted to CMS; and

3.7.2.2 Any documents incorporated by reference (including but not limited to State statute, regulation, or other binding document,

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such as a Member Handbook) to comply with federal regulations and the requirements of this review tool were submitted to CMS.

3.7.3 As part of this Agreement, DHHS shall submit to CMS for review and approval the MCO rate certifications concurrent with the review and approval process for this Agreement. [42 CFR 438.7(a)]

3.7.4 DHHS shall also submit to CMS for review and approval any Alternative Payment arrangements or other Provider payment arrangement initiatives based on DHHS's description of the initiatives submitted and approved outside of the Agreement. [42 CFR 438.6(c)]

3.8 Cooperation With Other Vendors and Prospective Vendors

3.8.1 This is not an exclusive Agreement and DHHS may award simultaneous and/or supplemental contracts for work related to the Agreement, or any portion thereof. The MCO shall reasonably cooperate with such other vendors; and shall not knowingly or negligently commit or permit any act that may interfere with the performance of work by any other vendor, or act in any way that may place Members at risk.

3.8.2 The MCO is required to notify DHHS within twelve (12) hours of a report by a Member, Member's relative, guardian or authorized representative of an allegation of a serious criminal offense against the Member by any employee of the MCO, its subcontractor or a Provider.

3.8.2.1 For the purpose of this Agreement, a serious criminal offense should be defined to include murder, arson, rape, sexual assault, assault, burglary, kidnapping, criminal trespass, or attempt thereof.

3.8.3 The MCO's notification shall be to a member of senior management of DHHS such as the Commissioner, Deputy Commissioner, Associate Commissioner, Medicaid Director, or Deputy Medicaid Director.

3.9 Renegotiation and Re-Procurement Rights

3.9.1 Renegotiation of Agreement

3.9.1.1 Notwithstanding anything in the Agreement to the contrary, DHHS may at any time during the Term exercise the option to notify the MCO that DHHS has elected to renegotiate certain terms of the Agreement.

3.9.1.2 Upon the MCO's receipt of any notice pursuant to this Section 3.9 (Renegotiation and Re-Procurement Rights) of the Agreement, the MCO and DHHS shall undertake good faith negotiations of the subject terms of the Agreement, and may execute

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an amendment to the Agreement subject to approval by Governor and Executive Council.

3.9.2 Re-Procurement of the Services or Procurement of Additional Services

3.9.2.1 Notwithstanding anything in the Agreement to the contrary, whether or not DHHS has accepted or rejected MCO's services and/or deliverables provided during any period of the Agreement, DHHS may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the scope of work covered by the Agreement or scope of work similar or comparable to the scope of work performed by the MCO under the Agreement.

3.9.2.2 DHHS shall give the MCO ninety (90) calendar days' notice of intent to replace another MCO participating in the MCM program or to add an additional MCO or other contractors to the MCM program.

3.9.2.3 If, upon procuring the services or deliverables or any portion of the services or deliverables from a Subcontractor in accordance with this section, DHHS, in its sole discretion, elects to terminate this Agreement, the MCO shall have the rights and responsibilities set forth in Section 7 (Termination of Agreement) and Section 5.7 (Dispute Resolution Process).

3.10 Organization Requirements

3.10.1 General Organization Requirements

3.10.1.1 As a condition to entering into this Agreement, the MCO shall be licensed by the NHID to operate as an HMO in the State as required by RSA 420-B, and shall have all necessary registrations and licensures as required by the NHID and any relevant State and federal laws and regulations.

3.10.1.2 As a condition to entering into this Agreement, and during the entire Agreement Term, the MCO shall ensure that its articles of incorporation and bylaws do not prohibit it from operating as an HMO or performing any obligation required under this Agreement.

3.10.1.3 The MCO shall not be located outside of the United States. [42 CFR 438.602(i)] The MCO is prohibited from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories.

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3.10.1.4 ~~[Amendment #9]~~[Amendment #8:] At the Department's discretion, the MCO shall initiate Centers for Medicare and Medicaid defined notification processes and application as may be appropriate to effectuate an integrated Medicare Advantage Duals-Special Needs Plan (D-SNP) targeting a beneficiary effective date at a date to be determined of January 1, 2024.

3.10.2 Articles

3.10.2.1 The MCO shall provide, by the beginning of each Agreement year and at the time of any substantive changes, written assurance from MCO's legal counsel that the MCO is not prohibited by its articles of incorporation from performing the services required under this Agreement.

3.10.3 Ownership and Control Disclosures

3.10.3.1 The MCO shall submit to DHHS the name of any persons or entities with an ownership or control interest in the MCO that:

3.10.3.1.1 Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the MCO's equity;

3.10.3.1.2 Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the MCO if that interest equals at least five percent (5%) of the value of the MCO's assets; or

3.10.3.1.3 Is an officer or director of an MCO organized as a corporation or is a partner in an MCO organized as a partnership. [Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]

3.10.3.2 The submission shall include for each person or entity, as applicable:

3.10.3.2.1 The address, including the primary business address, every business location, and P.O. Box address, for every entity;

3.10.3.2.2 The date of birth (DOB) and social security number (SSN) of any individual;

3.10.3.2.3 Tax identification number(s) of any corporation;

3.10.3.2.4 Information on whether an individual or entity with an ownership or control interest in the MCO is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

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3.10.3.2.5 Information on whether a person or corporation with an ownership or control interest in any Subcontractor in which the MCO has a five percent (5%) or more interest is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling;

3.10.3.2.6 The name of any other disclosing entity, as such term is defined in 42 CFR 455.101, in which an owner of the MCO has an ownership or control interest;

3.10.3.2.7 The name, address, DOB, and SSN of any managing employee of the MCO, as such term is defined by 42 CFR 455.101; and

3.10.3.2.8 Certification by the MCO's CEO that the information provided in this Section 3.10.3 (Ownership and Control Disclosures) to DHHS is accurate to the best of his or her information, knowledge, and belief.

3.10.3.3 The MCO shall disclose the information set forth in this Section 3.10.3 (Ownership and Control Disclosures) on individuals or entities with an ownership or control interest in the MCO to DHHS at the following times:

3.10.3.3.1 At the time of Agreement execution;

3.10.3.3.2 When the Provider or disclosing entity submits a Provider application;

3.10.3.3.3 When the Provider or disclosing entity executes a Provider agreement with DHHS;

3.10.3.3.4 Upon request of DHHS during the revalidation of the Provider enrollment; and

3.10.3.3.5 Within thirty-five (35) calendar days after any change in ownership of the disclosing entity. [Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 103; 42 CFR 455.104(c)(1) and (4)]

3.10.3.4 DHHS shall review the ownership and control disclosures submitted by the MCO and any Subcontractors. [42 CFR 438.602(c); 42 CFR 438.608(c)]

3.10.3.5 The MCO shall be fined in accordance with Exhibit N (Liquidated Damages Matrix) for any failure to comply with ownership disclosure requirements detailed in this Section.

3.10.4 Change in Ownership or Proposed Transaction

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3.10.4.1 The MCO shall inform DHHS and the NHID of its intent to merge with or be acquired, in whole or in part, by another entity or another MCO or of any change in control within seven (7) calendar days of a management employee learning of such intent. The MCO shall receive prior written approval from DHHS and the NHID prior to taking such action.

3.10.5 Prohibited Relationships

3.10.5.1 Pursuant to Section 1932(d)(1)(A) of the Social Security Act (42 USC 1396u-2(d)(1)(A)), the MCO shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of the MCO's equity who has been, or is affiliated with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(c)(2); Exec. Order No. 12549]

3.10.5.2 The MCO shall not have an employment, consulting, or any other contractual agreement or engage a Subcontractor, vendor or Provider who is a Sanctioned Individual or entity. In accordance with Section 1128(b)(8) of the Social Security Act, a Sanctioned Individual means a person who:

3.10.5.2.1 Has a direct or indirect ownership or control interest of 5 percent (5%) or more in the entity, and:

3.10.5.2.1.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.1.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.1.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.2 Has an ownership or control interest (as defined in Section 1124(a)(3) of the Social Security Act) in the entity, and:

3.10.5.2.2.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled

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substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.2.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.2.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.3 Is an officer, director, agent, or managing employee of the MCO, and:

3.10.5.2.3.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud, or

3.10.5.2.3.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.3.3. Has been excluded from participation under a program under title XVIII or under a state health care program; or

3.10.5.2.4 No longer has direct or indirect ownership or control interest of 5 percent (5%) or more in the MCO or no longer has an ownership or control interest defined under Section 1124(a)(3) of the Social Security Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who:

3.10.5.2.4.1. Has had a conviction relating to fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient abuse, or felony health care fraud,

3.10.5.2.4.2. Has been assessed a civil monetary penalty under Section 1128A or 1129 of the Social Security Act, or

3.10.5.2.4.3. Has been excluded from participation under a program under title XVIII or under a state health care program. [Section 1128(b)(8) of the Social Security Act]

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3.10.5.3 The MCO shall retain any data, information, and documentation regarding the above described relationships for a period of no less than ten (10) years.

3.10.5.4 Within five (5) calendar days of discovery, the MCO shall provide written disclosure to DHHS, and Subcontractors shall provide written disclosure to the MCO, which shall provide the same to DHHS, of any individual or entity (or affiliation of the individual or entity) who/that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or prohibited affiliation under 42 CFR 438.610. [Section 1932(d)(1) of the Social Security Act; 42 CFR 438.608(c)(1); 42 CFR 438.610(a)(1) - (2); 42 CFR 438.610(b); 42 CFR 438.610(c)(1) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549]

3.10.5.5 If DHHS learns that the MCO has a prohibited relationship with an individual or entity that (i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the MCO has relationship with an individual who is an affiliate of such an individual; (ii) is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act, DHHS may:

3.10.5.5.1 Terminate the existing Agreement with the MCO;

3.10.5.5.2 Continue an existing Agreement with the MCO unless the HHS Secretary directs otherwise;

3.10.5.5.3 Not renew or extend the existing Agreement with the MCO unless the HHS Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliation. [42 CFR 438.610(d)(2)-(3); 42 CFR 438.610(a); 42 CFR 438.610(b); Exec. Order No. 12549]

3.10.6 Background Checks and Screenings

3.10.6.1 The MCO shall perform criminal history record checks on its owners, directors, and managing employees, as such terms are defined in 42 CFR Section 455.101 and clarified in applicable

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subregulatory guidance such as the Medicaid Provider Enrollment Compendium.

3.10.6.2 [Amendment #8:] The MCO or its Subcontractors shall conduct ~~monthly~~ background checks upon hire and monthly on all ~~directors, officers, employees (or contractors and their employees) contractors or Subcontractors~~ to ensure that the MCO and Subcontractors ~~it does not employ or contract with any individual or entity:~~

3.10.6.2.1 Convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act;

3.10.6.2.2 Debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and/or

3.10.6.2.3 Is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act. [[42 CFR 438.808(a); 42 CFR 438.808(b)(1); 42 CFR 431.55(h); section 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; SMDL #09-001; 76 Fed. Reg. 5862, 5897 (February 2, 2011)]

3.10.6.3 [Amendment #8:] In addition, the MCO or its Subcontractor shall conduct screenings upon hire and monthly of its employees (except its directors and officers), and contractors and MCO Subcontractors' contractor employees (except its directors and officers) to ensure that none of them appear on: ~~In addition, the MCO shall conduct screenings of its directors, officers, employees, and contractors and Subcontractors to ensure that none of them appear on:~~

3.10.6.3.1 HHS-OIG's List of Excluded Individuals/Entities;

3.10.6.3.2 [Amendment #8:] The System of Award Management; and

3.10.6.3.3 [Amendment #8:] Intentionally left blank ~~The Social Security Administration Death Master File;~~

3.10.6.3.4 [Amendment #8:] The list maintained by the Office of Foreign Assets Control; and/or

3.10.6.3.5 To the extent applicable, NPPES (collectively, these lists are referred to as the "Exclusion Lists").

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~~3.10.6.4 [Amendment #8:] Intentionally left blank The MCO shall conduct screenings of all of its directors, officers, employees and Subcontractors monthly to ensure that none of the foregoing appear on any of the Exclusion Lists and that it continues to comply with Section 3.10.3 (Ownership and Control Disclosures) above. [SMDL #00-001; 76 Fed. Reg. 5862, 5897 (February 2, 2011)]~~

~~3.10.6.5 [Amendment #8:] The MCO shall certify to DHHS annually that it or its Subcontractors performs screenings upon hire and monthly thereafter against the Exclusion Lists and that neither the MCO nor its Subcontractors, including contractor employees of MCO Subcontractors, have any employees, directly or indirectly, with: The MCO shall certify to DHHS annually that it performs monthly screenings against the Exclusion Lists and that it does not have any director or officer or employ or contract, directly or indirectly, with:~~

~~3.10.6.5.1 Any individual or entity excluded from participation in the federal health care program;~~

~~3.10.6.5.2 Any entity for the provision of such health care, utilization review, medical social work, or administrative services through an excluded individual or entity or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;~~

~~3.10.6.5.3 Any individual or entity excluded from Medicare, Medicaid or NH participation by DHHS per the DHHS system of record;~~

~~3.10.6.5.4 Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act; and/or~~

~~3.10.6.5.5 Any individual entity appearing on any of the Exclusion Lists.~~

~~3.10.6.6 [Amendment #8:] In the event that the MCO or its Subcontractor identifies that it has employed or contracted with a person or entity which would make the MCO unable to certify as required under this Section 3.10.6 (Background Checks and Screenings) or Section 3.10.3 (Ownership and Control Disclosures) above, then the MCO should notify DHHS in writing and shall begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved waiver program.~~

~~3.10.6.7 [Amendment #8:] The MCO shall maintain documentation to ensure screenings have been completed by Subcontractors and reviewed by the MCO monthly.~~

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3.10.7 Conflict of Interest

3.10.7.1 The MCO shall ensure that safeguards, at a minimum equal to federal safeguards (41 USC 423, Section 27), are in place to guard against conflict of interest. [Section 1923(d)(3) of the Social Security Act; SMDL 12/30/97]. The MCO shall report transactions between the MCO and parties in interest to DHHS and any other agency as required, and make it available to MCO Members upon reasonable request. [Section 1903(m)(4)(B) of the Social Security Act]

3.10.7.2 The MCO shall report to DHHS and, upon request, to the HHS Secretary, the HHS Inspector General, and the Comptroller General a description of transactions between the MCO and a party in interest (as defined in Section 1318(b) of the Social Security Act), including the following transactions:

3.10.7.2.1 Any sale or exchange, or leasing of any property between the MCO and such a party;

3.10.7.2.2 Any furnishing for consideration of goods, services (including management services), or facilities between the MCO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and

3.10.7.2.3 Any lending of money or other extension of credit between the MCO and such a party. [Section 1903(m)(4)(A) of the Social Security Act; Section 1318(b) of the Social Security Act]

3.11 Confidentiality

3.11.1 Confidentiality of DHHS Information and Records

3.11.1.1 All information, reports, and records maintained hereunder or collected in connection with the performance of the services under the Agreement shall be confidential and shall not be disclosed by the MCO; provided however, that pursuant to State rules, State and federal laws and the regulations of DHHS regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Agreement; and provided further, that the use or disclosure by any party of any information concerning a Member for any purpose not directly connected with the administration of DHHS or the MCO's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his or her attorney or guardian.

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3.11.2 Request to DHHS of MCO Confidential or Proprietary Data or Information

3.11.2.1 DHHS may, in the course of carrying out its responsibilities under this Agreement, have or gain access to confidential or proprietary data or information owned or maintained by the MCO.

3.11.2.2 Insofar as the MCO seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the MCO shall clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential.

3.11.2.3 The MCO acknowledges that DHHS is subject to the Right-to-Know Law, RSA Chapter 91-A.

3.11.2.4 DHHS shall maintain the confidentiality of the identified Confidential Information insofar as it is consistent with applicable laws, rules, or regulations, including but not limited to RSA Chapter 91-A.

3.11.2.5 In the event DHHS receives a request for the information identified by the MCO as confidential, DHHS shall notify the MCO in writing and specify the date DHHS intends to release the requested information.

3.11.2.6 Any effort to prohibit or enjoin the release of the information shall be the MCO's responsibility and at the MCO's sole expense.

3.11.2.7 If the MCO fails to obtain a valid and enforceable court order in the State of New Hampshire enjoining the disclosure of the requested information within fifteen (15) business days of DHHS's written notification, DHHS may release the information on the date DHHS specified in its notice to the MCO without incurring any liability to the MCO.

3.12 Privacy and Security of Members' Information

3.12.1 The MCO shall be in compliance with privacy and security policies established by State or federal law, regulations or guidelines, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and their respective implementing regulations, federal statutes and regulations governing the privacy of Substance Use Disorder patient records (42 CFR, Part 2), and all applicable State statutes, rules and regulations including, but not limited to, RSA 167:30.

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3.12.2 The MCO shall protect the confidentiality of all DHHS records with identifying medical information in them. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(ii)]

3.12.3 The MCO shall execute as part of this Agreement, a Business Associate Agreement, as such term is defined by HIPAA, and the DHHS information security requirements as outlined in Exhibit I (HIPAA Business Associate Agreement), governing the permitted uses, disclosure and security of Protected Health Information (PHI), as such term is defined by HIPAA, and as provided by DHHS to the MCO.

3.12.4 The MCO shall ensure that if Member Substance Use Disorder records or data protected by 42 CFR Part 2 are created, maintained, or disclosed, any record or data shall be safeguarded according to the requirements found in 42 CFR Part 2, and that Member consent is obtained as required by 42 CFR Part 2.

3.12.5 The MCO shall ensure that it secures and protects the State and DHHS data when such data resides on the MCO's network, when in transit, and while stored and cached.

3.12.6 State and DHHS data shall be encrypted while in transit.

3.12.7 The MCO shall ensure that it secures and protects DHHS data if any DHHS data or Member records or data are transmitted by fax, and shall ensure that appropriate notices relating to confidentiality or erroneous transmission are used with each fax transmission.

3.12.8 With the exception of submission to the CHIS or other requirements of State or federal law or the terms of this Agreement, claims and Member data on NH Medicaid Members may not be released to any party without the express written consent of DHHS.

3.12.9 The MCO shall maintain written policies and procedures ensuring compliance with this Section 3.12 (Privacy and Security of Members' Information), which shall be available to DHHS upon request.

3.12.10 In the event that the MCO or one of its Subcontractors had a breach, as such term is defined by HIPAA, or had an unauthorized disclosure of State or DHHS data, the MCO shall notify DHHS within two (2) hours of knowledge that such breach or unauthorized disclosure has been confirmed. Failure to adequately protect Member information, DHHS claims, and other data may subject the MCO to sanctions and/or the imposition of liquidated damages in accordance with Section 5.5.2 (Liquidated Damages).

3.13 Compliance With State and Federal Laws

3.13.1 General Requirements

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3.13.1.1 [Amendment #10:] The MCO, its Subcontractors, and Participating Providers, shall adhere to all applicable State and federal laws and applicable regulations and subregulatory guidance which provides further interpretation of law, including subsequent revisions whether or not listed in this Section 3.13 (Compliance with State and Federal Laws), and any laws, regulations or administrative rules effective after the execution of this Agreement. The MCO shall comply with any applicable federal and State laws that pertain to Member rights and ensure that its employees and Participating Providers observe and protect those rights. [42 CFR 438.100(a)(2)]

3.13.1.2 The MCO shall comply, at a minimum, with the following:

3.13.1.2.1 Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. Section 1395 et seq.; Related rules: Title 42 Chapter IV;

3.13.1.2.2 Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. Section 1396 et seq. (specific to managed care: Section 1902(a)(4), 1903(m), 1905(t), and 1932 of the SSA); Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR Section 438; see also 431 and 435);

3.13.1.2.3 CHIP: Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397; Regulations promulgated thereunder: 42 CFR 457;

3.13.1.2.4 Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;

3.13.1.2.5 State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;

3.13.1.2.6 State administrative rules and laws pertaining to confidentiality;

3.13.1.2.7 American Recovery and Reinvestment Act;

3.13.1.2.8 Title VI of the Civil Rights Act of 1964;

3.13.1.2.9 The Age Discrimination Act of 1975;

3.13.1.2.10 The Rehabilitation Act of 1973;

3.13.1.2.11 Title IX of the Education Amendments of 1972 (regarding education programs and activities);

3.13.1.2.12 The ADA;

3.13.1.2.13 42 CFR Part 2; and

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3.13.1.2.14 Section 1557 of the Affordable Care Act. [42 CFR 438.3(f)(1); 42 CFR 438.100(d)]

3.13.1.3 [Amendment #10:] The MCO shall comply with all aspects of the DHHS Sentinel Event Reporting and Review Policy PR 10-01, effective September 2010 PO.1003, and any subsequent versions and/or amendments;

3.13.1.3.1 [Amendment #10:] The MCO shall 1) cooperate with review of any reported any investigation of a Ssentinel event, including involvement in the Sentinel Event Review team, and provide any additional reporting information requested by DHHS, and 2) participate in a DHHS sentinel event review, if requested to conduct the Sentinel Event Review;

3.13.1.3.2 The MCO shall report to DHHS within twenty-four (24) hours any time a sentinel event occurs with one of its Members. This does not replace the MCO's responsibility to notify the appropriate authority if the MCO suspects a crime has occurred;

3.13.1.3.3 The MCO shall comply with all statutorily mandated reporting requirements, including but not limited to, RSA 161-F:42-54 and RSA 169-C:29;

3.13.1.3.4 In instances where the time frames detailed in the Agreement conflict with those in the DHHS Sentinel Event Policy, the policy requirements will prevail.

3.13.2 Non-Discrimination

3.13.2.1 The MCO shall require Participating Providers and Subcontractors to comply with the laws listed in Section 3.13.1 (General Requirements) above, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. [42 CFR 438.3(d)(4)]

3.13.3 Reporting Discrimination Grievances

3.13.3.1 The MCO shall forward to DHHS copies of all grievances alleging discrimination against Members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability or

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gender identity for review and appropriate action within three (3) business days of receipt by the MCO.

3.13.3.2 Failure to submit any such grievance within three (3) business days may result in the imposition of liquidated damages as outlined in Section 5.5.2. (Liquidated Damages).

3.13.4 Americans with Disabilities Act

3.13.4.1 The MCO shall have written policies and procedures that ensure compliance with requirements of the ADA, and a written plan to monitor compliance to determine the ADA requirements are being met.

3.13.4.2 The ADA compliance plan shall be sufficient to determine the specific actions that shall be taken to remove existing barriers and/or to accommodate the needs of Members who are qualified individuals with a disability.

3.13.4.3 The ADA compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all Members who are qualified individuals with a disability, including but not limited to street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

3.13.4.4 A "Qualified Individual with a Disability," defined pursuant to 42 U.S.C. Section 12131(2), is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of Auxiliary Aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

3.13.4.5 The MCO shall require Participating Providers and Subcontractors to comply with the requirements of the ADA. In providing Covered Services, the MCO shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid Members who are qualified individuals with disabilities covered by the provisions of the ADA.

3.13.4.6 The MCO shall survey Participating Providers of their compliance with the ADA using a standard survey document that shall be provided by DHHS. Completed survey documents shall be kept on file by the MCO and shall be available for inspection by DHHS.

3.13.4.7 The MCO shall, in accordance with Exhibit G (Certification Regarding ADA Compliance), annually submit to DHHS a written

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certification that it is conversant with the requirements of the ADA, that it is in compliance with the ADA, that it has complied with this Section 3.13.4 (Americans with Disabilities Act) of the Agreement, and that it has assessed its Participating Provider network and certifies that Participating Providers meet ADA requirements to the best of the MCO's knowledge.

3.13.4.8 The MCO warrants that it shall hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the MCO to be in compliance with the ADA.

3.13.4.9 Where applicable, the MCO shall abide by the provisions of Section 504 of the Federal Rehabilitation Act of 1973, as amended, 29 U.S.C. Section 794, regarding access to programs and facilities by people with disabilities.

3.13.5 Non-Discrimination in Employment

3.13.5.1 The MCO shall not discriminate against any employee or applicant for employment because of age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

3.13.5.2 The MCO shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

3.13.5.3 Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship.

3.13.5.4 The MCO agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

3.13.5.5 The MCO shall, in all solicitations or advertisements for employees placed by or on behalf of the MCO, state that all qualified applicants shall receive consideration for employment without regard to age, sex, gender identity, race, color, sexual orientation, marital status, familial status, or physical or mental disability, religious creed or national origin.

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3.13.5.6 The MCO shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other agreement or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of the MCO's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.13.5.7 The MCO shall comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.13.5.8 The MCO shall furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and shall permit access to its books, records, and accounts by DHHS and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.13.5.9 The MCO shall include the provisions described in this Section 3.13.5 (Non-Discrimination in Employment) in every contract with a Subcontractor or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions shall be binding upon each Subcontractor or vendor.

3.13.5.10 The MCO shall take such action with respect to any contract with a Subcontractor or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance, provided, however, that in the event the MCO becomes involved in, or is threatened with, litigation with a Subcontractor or vendor as a result of such direction, the MCO may request the United States to enter into such litigation to protect the interests of the United States.

3.13.6 Non-Compliance

3.13.6.1 In the event of the MCO's noncompliance with the non-discrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated or suspended in whole or in part and the MCO may be declared ineligible for further government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24,

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1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.13.7 Changes in Law

3.13.7.1 The MCO shall implement appropriate program, policy or system changes, as required by changes to State and federal laws or regulations or interpretations thereof.

3.14 Subcontractors

3.14.1 MCO Obligations

3.14.1.1 The MCO shall maintain ultimate responsibility for adhering to, and otherwise fully complying with the terms and conditions of this Agreement, notwithstanding any relationship the MCO may have with the Subcontractor, including being subject to any remedies contained in this Agreement, to the same extent as if such obligations, services and functions were performed by the MCO.

3.14.1.2 For the purposes of this Agreement, such work performed by any Subcontractor shall be deemed performed by the MCO. [42 CFR 438.230(b)]

3.14.1.3 DHHS reserves the right to require the replacement of any Subcontractor or other contractor found by DHHS to be unacceptable or unable to meet the requirements of this Agreement, and to object to the selection or use of a Subcontractor or contract.

3.14.1.4 The MCO, regardless of its written agreements with any Subcontractors, maintains ultimate responsibility for complying with this Agreement.

3.14.1.5 The MCO shall have oversight of all Subcontractors' policies and procedures for compliance with the False Claims Act (FCA) and other State and federal laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

3.14.2 Contracts with Subcontractors

3.14.2.1 The MCO shall have a written agreement between the MCO and each Subcontractor which includes, but shall not be limited to:

3.14.2.1.1 All required activities and obligations of the Subcontractor and related reporting responsibilities and safeguarding of Confidential Information according to State rules, and State and federal laws;

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- 3.14.2.1.2 Full disclosure of the method and amount of compensation or other consideration received by the Subcontractor;
- 3.14.2.1.3 Amount, duration, and scope of services to be provided by the Subcontractor;
- 3.14.2.1.4 Term of the agreement, methods of extension, and termination rights;
- 3.14.2.1.5 The process to transition services when the agreement expires or terminates;
- 3.14.2.1.6 Information about the grievance and appeal system and the rights of the Member as described in 42 CFR 438.414 and 42 CFR 438.10(g);
- 3.14.2.1.7 Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement;
- 3.14.2.1.8 Requirements for the Subcontractor:
 - 3.14.2.1.8.1. To hold harmless DHHS and its employees, and all Members served under the terms of this Agreement in the event of non-payment by the MCO;
 - 3.14.2.1.8.2. To indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors;
- 3.14.2.1.9 Requirements that provide that:
 - 3.14.2.1.9.1. The MCO, DHHS, NH Medicaid Fraud Control Unit (MFCU), NH Department of Justice (DOJ), U.S. DOJ, the OIG, and the Comptroller General or their respective designees shall have the right to audit, evaluate, and inspect, and that it shall make available for the purpose of audit, evaluation or inspection, any premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of the services and/or activities performed or determination of amounts payable under

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this Agreement; [42 CFR 438.230(c)(3)(i) & (ii); 42 CFR 438.3(k)]

3.14.2.1.9.2. The Subcontractor shall further agree that it can be audited for ten (10) years from the final date of the Term or from the date of any completed audit, whichever is later; and [42 CFR 438.230(c)(3)(iii); 42 CFR 438.3(k)]

3.14.2.1.9.3. The MCO, DHHS, MFCU, NH DOJ, U.S. DOJ, OIG, and the Comptroller General or their respective designees may conduct an audit at any time if DHHS, MFCU, NH DOJ, U.S. DOJ, the OIG, and the Comptroller General or their respective designee determines that there is a reasonable possibility of fraud, potential Member harm or similar risk. [42 CFR 438.230(c)(3)(iv); 42 CFR 438.3(k)]

3.14.2.1.10 Subcontractor's agreement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority;

3.14.2.1.11 Require Subcontractor to submit ownership and controlling interest information as required by Section 3.10.3 (Ownership and Control Disclosures);

3.14.2.1.12 Require Subcontractors to investigate and disclose to the MCO, at contract execution or renewal, and upon request by the MCO of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid since the inception of those programs and who is [42 CFR 455.106(a)]:

3.14.2.1.12.1. A person who has an ownership or control interest in the Subcontractor or Participating Provider; [42 CFR 455.106(a)(1)]

3.14.2.1.12.2. An agent or person who has been delegated the authority to obligate or act on behalf of the Subcontractor or Participating Provider; or [42 CFR 455.101; 42 CFR 455.106(a)(1)]

3.14.2.1.12.3. An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the Subcontractor or

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Participating Provider [42 CFR 455.101; 42 CFR 455.106(a)(2)]

3.14.2.1.13 Require Subcontractor to screen its directors, officers, employees, contractors and Subcontractors against each of the Exclusion Lists on a monthly basis and report to the MCO any person or entity appearing on any of the Exclusion Lists and begin termination proceedings within forty-eight (48) hours unless the individual is part of a federally-approved waiver program;

3.14.2.1.14 Require Subcontractor to have a compliance plan that meets the requirements of 42 CFR Section 438.608 and policies and procedures that meet the Deficit Reduction Act (DRA) of 2005 requirements;

3.14.2.1.15 Prohibit Subcontractor from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories;

3.14.2.1.16 A provision for revoking delegation of activities or obligations, or imposing other sanctions if the Subcontractor's performance is determined to be unsatisfactory by the MCO or DHHS;

3.14.2.1.17 Subcontractor's agreement to comply with the ADA, as required by Section 3.13.4 (Americans with Disabilities Act) above;

3.14.2.1.18 Include provisions of this Section 3.14.2 (Contracts with Subcontractors) in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965;

3.14.2.1.19 Require any Subcontractor, to the extent that the Subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under this Agreement, to implement policies and procedures, as reviewed by DHHS, for reporting of all Overpayments identified, including embezzlement or receipt of Capitation Payments to which it was not entitled or recovered, specifying the Overpayments due to potential fraud, to the State.

3.14.2.1.20 Require any Subcontractor to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and Agreement provisions. [42 CFR 438.230(c)(2); 42 CFR 438.3(k)]

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3.14.2.1.21 Require any Subcontractor to comply with any other provisions specifically required under this Agreement or the applicable requirements of 42 CFR 438. [42 CFR 438.230]

3.14.2.2 The MCO shall notify DHHS in writing within one (1) business day of becoming aware that its Subcontractor is cited as non-compliant or deficient by any State or federal regulatory authority.

3.14.2.3 If any of the MCO's activities or obligations under this Agreement are delegated to a Subcontractor:

3.14.2.3.1 The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the MCO and the Subcontractor; and

3.14.2.3.2 The contract or written arrangement between the MCO and the Subcontractor shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the state or the MCO determines that the Subcontractor has not performed satisfactorily. [42 CFR 438.230(c)(1)(i) - (iii); 42 CFR 438.3(k)]

3.14.2.4 Subcontractors or any other party performing utilization review are required to be licensed in NH.

3.14.3 Notice and Approval

3.14.3.1 The MCO shall submit all Subcontractor agreements and Subcontractor Provider agreements to DHHS, for review at least sixty (60) calendar days prior to the anticipated implementation date of that Subcontractor agreement, any time there is a renewal or extension amendment to a Subcontractor agreement already reviewed by DHHS or there is a substantial change in scope or terms of the Subcontractor agreement.

3.14.3.2 The MCO remains responsible for ensuring that all Agreement requirements are met, including requirements requiring the integration of physical and behavioral health, and that the Subcontractor adheres to all State and federal laws, regulations and related guidance and guidelines.

3.14.3.3 The MCO shall notify DHHS of any change in Subcontractors and shall submit a new Subcontractor agreement for review sixty (60) calendar days prior to the start date of the new Subcontractor agreement.

3.14.3.4 Review by DHHS of a Subcontractor agreement does not relieve the MCO from any obligation or responsibility regarding the

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Subcontractor and does not imply any obligation by DHHS regarding the Subcontractor or Subcontractor agreement.

3.14.3.5 DHHS may grant a written exception to the notice requirements of this Section 3.14.3 (Notice and Approval) if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

3.14.3.6 The MCO shall notify DHHS within five (5) business days of receiving notice from a Subcontractor of its intent to terminate a Subcontractor agreement.

3.14.3.7 The MCO shall notify DHHS of any material breach by Subcontractor of an agreement between the MCO and the Subcontractor that may result in the MCO being non-compliant with or violating this Agreement within one (1) business day of validation that such breach has occurred.

3.14.3.8 The MCO shall take any actions directed by DHHS to cure or remediate said breach by the Subcontractor.

3.14.3.9 In the event of material change, breach or termination of a Subcontractor agreement between the MCO and a Subcontractor, the MCO's notice to DHHS shall include a transition plan for DHHS's review and approval.

3.14.4 MCO Oversight of Subcontractors

3.14.4.1 The MCO shall provide its Subcontractors with training materials regarding preventing fraud, waste and abuse and shall require the MCO's hotline to be publicized to Subcontractors' staff who provide services to the MCO.

3.14.4.2 The MCO shall oversee and be held accountable for any functions and responsibilities that it delegates to any Subcontractor in accordance with 42 CFR 438.230 and 42 CFR Section 438.3, including:

3.14.4.2.1 Prior to any delegation, the MCO shall evaluate the prospective Subcontractor's ability to perform the Social Security activities to be delegated;

3.14.4.2.2 The MCO shall audit the Subcontractor's compliance with its agreement with the MCO and the applicable terms of this Agreement, at least annually and when there is a substantial change in the scope or terms of the Subcontractor agreement; and

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3.14.4.2.3 The MCO shall identify deficiencies or areas for improvement, if any. The MCO shall prompt the Subcontractor to take corrective action.

3.14.4.3 The MCO shall develop and maintain a system for regular and periodic monitoring of each Subcontractor's compliance with the terms of its agreement and this Agreement.

3.14.4.4 If the MCO identifies deficiencies or areas for improvement in the Subcontractor's performance that affect compliance with this Agreement, the MCO shall notify DHHS within seven (7) calendar days and require the Subcontractor to develop a CAP. The MCO shall provide DHHS with a copy of the Subcontractor's CAP within thirty (30) calendar days upon DHHS request, which is subject to DHHS approval [42 CFR 438.230 and 42 CFR Section 438.3]

3.15 Staffing

3.15.1 Key Personnel

3.15.1.1 The MCO shall commit key personnel to the MCM program on a full-time basis. Positions considered to be key personnel, along with any specific requirements for each position, include:

3.15.1.1.1 CEO/Executive Director: Individual shall have clear authority over the general administration and day-to-day business activities of this Agreement.

3.15.1.1.2 Finance Officer: Individual shall be responsible for accounting and finance operations, including all audit activities.

3.15.1.1.3 Medical Director: Individual shall be a physician licensed by the NH Board of Medicine, shall oversee and be responsible for all clinical activities, including but not limited to, the proper provision of Covered Services to Members, developing clinical practice standards and clinical policies and procedures.

3.15.1.1.3.1. The Medical Director shall have substantial involvement in QAPI Program activities and shall attend monthly, or as otherwise requested, in-person meetings with the DHHS Medical Director.

3.15.1.1.3.2. The Medical Director shall have a minimum of five (5) years of experience in government programs (e.g. Medicaid, Medicare, and Public Health).

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3.15.1.1.3.3. The Medical Director shall have oversight of all utilization review techniques and methods and their administration and implementation.

3.15.1.1.4 Quality Improvement Director: Individual shall be responsible for all QAPI program activities.

3.15.1.1.4.1. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement meetings with DHHS and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.15.1.1.5 Compliance Officer: Individual shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement.

3.15.1.1.5.1. The Compliance Officer shall report directly to the NH-based CEO or the executive director thereof.

3.15.1.1.6 Network Management Director: Individual shall be responsible for development and maintenance of the MCO's Participating Provider network.

3.15.1.1.7 Provider Relations Manager: Individual shall be responsible for provision of all MCO Provider services activities.

3.15.1.1.7.1. The manager shall have prior experience with individual physicians, Provider groups and facilities.

3.15.1.1.8 Member Services Manager: Individual shall be responsible for provision of all MCO Member Services activities.

3.15.1.1.8.1. The manager shall have prior experience with Medicaid populations.

3.15.1.1.9 Utilization Management (UM) Director: Individual shall be responsible for all UM activities.

3.15.1.1.9.1. This person shall be under the direct supervision of the Medical Director and shall ensure that UM staff has appropriate clinical backgrounds in order to make appropriate UM decisions regarding Medically Necessary Services.

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3.15.1.1.9.2. The MCO shall also ensure that the UM program assigns responsibility to appropriately licensed clinicians, including a behavioral health and a LTSS professional for those respective services.

3.15.1.1.10 Systems Director/Manager: Individual shall be responsible for all MCO information systems supporting this Agreement, including but not limited to continuity and integrity of operations, continuity flow of records with DHHS's information systems and providing necessary and timely reports to DHHS.

3.15.1.1.11 Encounter Manager: Individual shall be responsible for and qualified by training and experience to oversee encounter submittal and processing to ensure the accuracy, timeliness, and completeness of encounter reporting.

3.15.1.1.12 Claims Manager: Individual shall be responsible for and qualified by training and experience to oversee claims processing and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

3.15.1.1.13 Pharmacy Manager: Individual shall be a pharmacist licensed by the NH Board of Pharmacy and shall have a minimum of five (5) years pharmacy experience as a practicing pharmacist.

3.15.1.1.13.1. The individual shall be responsible for all pharmacy activities, including but not limited to the Lock-In Program, coordinating clinical criteria for Prior Authorizations, compliance with the opioid prescribing requirements outlined in Section 4.11.6 (Substance Use Disorder) and overseeing the Drug Utilization Review (DUR) Board or the Pharmacy and Therapeutics Committee.

3.15.1.1.14 [Amendment #8:] Substance Use Disorder Physician: Effective July 1, 2022, individual shall be an Addiction Medicine Physician licensed by the NH Board of Medicine, and participate under the terms of this Agreement without regard to leeway previously granted by DHHS.

3.15.1.1.14.1. The individual shall be responsible for providing clinical oversight and guidance for the MCO on Substance Use Disorder issues, including issues such as the use of ASAM or other evidence-based assessments and treatment protocols, the use of MAT, engagements with PRSS, and discharge planning for

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Members who visit an ED or are hospitalized for an overdose.

3.15.1.1.14.2. The Substance Use Disorder Physician shall be available to the MCM program on a routine basis for consultations on MCO clinical policy related to Substance Use Disorders and the cases of individual Members, as needed.

3.15.1.2 Coordinators shall be responsible for overseeing Care Coordination and Care Management activities for MCO Members with complex medical, behavioral health, DD, and long term care needs; or for overseeing other activities.

3.15.1.3 Coordinators shall also serve as liaisons to DHHS staff for their respective functional areas. The MCO shall assign coordinators to each of the following areas on a full-time basis:

3.15.1.3.1 Special Needs Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.15.1.3.1.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities with a particular focus on special needs populations.

3.15.1.3.1.2. The Special Needs Coordinator shall be responsible for ensuring compliance with and implementation of requirements for Adults and Children with Special Care Needs related to Care Management, Network Adequacy, access to Benefits, and Utilization Management.

3.15.1.3.1.3. [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ ~~2021~~, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions.

3.15.1.3.2 Developmental Disability Coordinator: Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

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3.15.1.3.2.1. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities related to services provided for developmentally disabled individuals.

3.15.1.3.2.2. The Developmental Disability Coordinator shall be responsible for ensuring coordination with LTSS Case Managers for Members enrolled in the MCO but who have services covered outside of the MCO's Covered Services.

3.15.1.3.2.3. [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022-2024~~, the Developmental Disability and Special Needs Coordinator positions may be either consolidated or re-established as part-time positions.

3.15.1.3.3 Mental Health Coordinator: Individual shall oversee the delivery of Mental Health Services to ensure that there is a single point of oversight and accountability.

3.15.1.3.3.1. Individual shall have a minimum of a Master's Degree from a recognized college or university with major study in Social Work, Psychology, Education, Public Health or a related field.

3.15.1.3.3.2. Individual shall have a minimum of eight (8) years demonstrated experience both in the provision of direct care services as well as progressively increasing levels of management responsibilities, with a particular focus on direct care and administrative responsibilities within Community Mental Health Services.

3.15.1.3.3.3. Other key functions shall include coordinating Mental Health Services across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; implementation and interpretation of clinical

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policies and procedures; and Social Determinants of Health and community-based resources.

3.15.1.3.4 Substance Use Disorder Coordinator: Individual shall be an addiction medicine specialist on staff or under contract who works with the Substance Use Disorder Physician to provide clinical oversight and guidance to the MCO on Substance Use Disorder issues.

3.15.1.3.4.1. The Substance Use Disorder Coordinator shall be a Masters Licensed Alcohol and Drug Counselor (MLADC) or Licensed Mental Health Professional who is able to demonstrate experience in the treatment of Substance Use Disorder.

3.15.1.3.4.2. The individual shall have expertise in screening, assessments, treatment, and Recovery strategies; use of MAT; strategies for working with child welfare agencies, correctional institutions and other health and social service agencies that serve individuals with Substance Use Disorders.

3.15.1.3.4.3. The individual shall be available to the MCM program on a routine basis for consultations on clinical, policy and operational issues, as well as the disposition of individual cases.

3.15.1.3.4.4. Other key functions shall include coordinating Substance Use Disorder services and treatment across all functional areas including: quality management; oversight of the behavioral health Subcontract, as applicable; Care Management; Utilization Management; network development and management; Provider relations; and social determinants of health and community-based resources.

3.15.1.3.5 Long Term Care Coordinator: Individual shall be responsible for coordinating managed care Covered Services with FFS and waiver programs.

3.15.1.3.5.1. The individual shall have a minimum of a Master's Degree in a Social Work, Psychology, Education, Public Health or a related field and have a minimum of eight (8) years of demonstrated experience both in the provision of direct care services at progressively increasing levels of management

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responsibilities, with a particular focus on direct care and administrative responsibilities related to long term care services.

3.15.1.3.5.2. [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:]
For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ 2021, the Long Term Care Coordinator position is not required.

3.15.1.3.6 Grievance Coordinator: Individual shall be responsible for overseeing the MCO's Grievance System.

3.15.1.3.7 Fraud, Waste, and Abuse Coordinator: Individual shall be responsible for tracking, reviewing, monitoring, and reducing fraud, waste and abuse.

3.15.1.3.8 [Amendment #5:] Housing Coordinator: Except as described at Sections 3.15.1.3.8.7, 3.15.2.4.5, and 4.11.5.7.2.1, the individual shall be responsible for helping to identify, secure, and maintain community based housing for Members and developing, articulating, and implementing a broader housing strategy within the MCO to expand housing availability/options.

3.15.1.3.8.1. The Housing Coordinator shall act as the MCO's central housing expert/resource, providing education and assistance to all MCO's relevant staff (care managers and others) regarding supportive housing services and related issues.

3.15.1.3.8.2. The Housing Coordinator shall be a dedicated staff person whose primary responsibility is housing-related work.

3.15.1.3.8.3. The Housing Coordinator shall not be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO.

3.15.1.3.8.4. The Housing Coordinator shall act as a liaison with the Department's Bureau of Housing and Homeless Services to receive training and work in collaboration on capacity requirements/building.

3.15.1.3.8.5. The Housing Coordinator shall have at least two (2) year's full-time experience is assisting vulnerable populations to secure accessible, affordable housing.

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3.15.1.3.8.6. The Coordinator shall be familiar with the relevant public and private housing resources and stakeholders.

3.15.1.3.8.7. [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ 2021, the Housing Coordinator position is not required.

3.15.1.3.9 Prior Authorization Coordinator: Individual shall be responsible for all MCO Utilization Management activities and shall work under the direct supervision of the Medical Director.

3.15.1.3.9.1. The Prior Authorization Coordinator shall ensure that all staff performing prior authorization functions have the necessary clinical backgrounds needed to apply established coverage criteria and make appropriate decisions based on medical necessary.

3.15.1.3.9.2. The individual shall be licensed by the NH Board of Nursing and have a minimum of eight (8) years of demonstrated experience in both the provision of direct clinical services as well as progressively increasing levels of management responsibilities with a particular focus on performance of a variety of utilization functions including conducting inter-rater reliability quality audits.

3.15.2 Other MCO Required Staff

3.15.2.1 Fraud, Waste, and Abuse Staff: The MCO shall establish a Special Investigations Unit (SIU), which shall be comprised of experienced fraud, waste and abuse investigators who have the appropriate training, education, experience, and job knowledge to perform and carry out all of the functions, requirements, roles and duties contained herein.

3.15.2.1.1 At a minimum, the SIU shall have at least two (2) fraud, waste and abuse investigators and one (1) Fraud, Waste and Abuse Coordinator.

3.15.2.1.2 The MCO shall adequately staff the SIU to ensure that the MCO meets Agreement provisions of Section 5.3.2 (Fraud, Waste and Abuse).

3.15.2.2 Behavioral Health Clinical Providers to Minimize Psychiatric Boarding: The MCO shall supply a sufficient number of

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hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to, or at risk for, Psychiatric Boarding.

3.15.2.2.1 The number of such hospital-credentialed Providers shall be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed.

3.15.2.2.2 The initial on-site assistance provided within these required timelines shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or another Designated Receiving Facility.

3.15.2.2.3 Each such hospital-credentialed Provider shall have the clinical expertise to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources, that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required.

3.15.2.2.3.1. [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023 June 30, December 31, 2022~~ 2021, the Psychiatric Boarding program's hospital-credentialed Provider position(s) are not required.

3.15.2.3 [Amendment #8:] Staff for Members at New Hampshire Hospital: The MCO shall designate an off-site ~~on-site~~ liaison with privileges at New Hampshire Hospital to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process ~~for Members admitted to New Hampshire Hospital.~~

3.15.2.3.1 [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023 June 30 December 31, 2022~~ 2021, the Staff for Members at New Hampshire Hospital position is not required.

3.15.2.4 [Amendment #5:] Additional Behavioral Health Staff: Except as described at Sections 3.15.1.3.8.7, 3.15.2.4.5, and 4.11.5.7.2.1, the MCO shall designate one (1) or more staff who have behavioral health specific managed care experience to provide in-person housing ~~in-person housing~~ assistance to Members who are homeless and oversee:

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- 3.15.2.4.1 Behavioral health Care Management;
- 3.15.2.4.2 Behavioral health Utilization Management;
- 3.15.2.4.3 Behavioral health network development; and
- 3.15.2.4.4 The behavioral health Subcontract, as applicable.
- 3.15.2.4.5 Amendment #10: [Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:] For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ ~~June 30~~ ~~December 31, 2022~~ 2024, the Behavioral Health Staff position responsible for in-person housing assistance is not required.
- 3.15.2.5 Any subcontracted personnel or entity engaged in decision-making for the MCO regarding clinical policies related to Substance Use Disorder or mental health shall have demonstrated experience working in direct care for Members with Substance Use Disorder or mental health.
- 3.15.2.6 Amendment #5: ~~The crisis lines and~~ Emergency Services teams shall employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention calls and who have access to a clinician available to evaluate the Member on a face-to-face basis in the community to address the crisis and evaluate the need for hospitalization.

3.15.3 On-Site Presence

- 3.15.3.1 The MCO shall have an on-site presence in New Hampshire. On-site presence for the purposes of this Section 3.15.3 of the Agreement means that the MCO's personnel identified below regularly reports to work in the State of New Hampshire:
 - 3.15.3.1.1 CEO/Executive Director;
 - 3.15.3.1.2 Medical Director;
 - 3.15.3.1.3 Amendment #5: ~~Intentionally Left Blank~~ Quality Improvement Director;
 - 3.15.3.1.4 Amendment #5: ~~Intentionally Left Blank~~ Compliance Officer;
 - 3.15.3.1.5 Network Management Director;
 - 3.15.3.1.6 Provider Relations Manager;
 - 3.15.3.1.7 Amendment #5: ~~Intentionally Left Blank~~ Utilization Management Director;
 - 3.15.3.1.8 Pharmacy Manager;

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- 3.15.3.1.9 Substance Use Disorder Physician;
 - 3.15.3.1.10 Special Needs Coordinator;
 - 3.15.3.1.11 Mental Health Coordinator;
 - 3.15.3.1.12 Substance Use Disorder Coordinator;
 - 3.15.3.1.13 DD Coordinator;
 - 3.15.3.1.14 Long Term Care Coordinator;
 - 3.15.3.1.15 Housing Coordinator;
 - 3.15.3.1.16 Grievance Coordinator;
 - 3.15.3.1.17 Fraud, Waste, and Abuse Coordinator; and
 - 3.15.3.1.18 [Amendment #5:] Intentionally Left Blank Prior Authorization Coordinator.
- 3.15.3.2 Upon DHHS's request, MCO required staff who are not located in New Hampshire shall travel to New Hampshire for in-person meetings.
- 3.15.3.3 The MCO shall provide to DHHS for review and approval key personnel and qualifications no later than sixty (60) calendar days prior to the start of the program.
- 3.15.3.4 The MCO shall staff the program with the key personnel as specified in this Agreement, or shall propose alternate staffing subject to review and approval by DHHS, which approval shall not be unreasonably withheld.
- 3.15.3.5 [Amendment #5:] DHHS may grant a written exception to the notice requirements of this section if, in DHHS's reasonable determination, the MCO has shown good cause for a shorter notice period.

3.15.4 General Staffing Provisions

- 3.15.4.1 The MCO shall provide sufficient staff to perform all tasks specified in this Agreement. The MCO shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties in a timely manner as contained herein. In the event that the MCO does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles, and duties, DHHS may impose liquidated damages, in accordance with Section 5.5.2 (Liquidated Damages).
- 3.15.4.2 The MCO shall ensure that all staff receive appropriate training, education, experience, and orientation to fulfill the

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requirements of the positions they hold and shall verify and document that it has met this requirement.

3.15.4.2.1 This includes keeping up-to-date records and documentation of all individuals requiring licenses and/or certifications and such records shall be available for DHHS inspection.

3.15.4.3 All key personnel shall be generally available during DHHS hours of operation and available for in-person or video conferencing meetings as requested by DHHS.

3.15.4.3.1 The MCO key personnel, and others as required by DHHS, shall, at a minimum, be available for monthly in-person meetings in NH with DHHS.

3.15.4.4 The MCO shall make best efforts to notify DHHS at least thirty (30) calendar days in advance of any plans to change, hire, or reassign designated key personnel.

3.15.4.5 If a member of the MCO's key personnel is to be replaced for any reason while the MCO is under Agreement, the MCO shall inform DHHS within seven (7) calendar days, and submit a transition plan with proposed alternate staff to DHHS for review and approval, for which approval shall not be unreasonably withheld.

3.15.4.5.1 The Staffing Transition Plan shall include, but is not limited to:

3.15.4.5.1.1. The allocation of resources to the Agreement during key personnel vacancy;

3.15.4.5.1.2. The timeframe for obtaining key personnel replacements within ninety (90) calendar days; and

3.15.4.5.1.3. The method for onboarding staff and bringing key personnel replacements/additions up-to-date regarding this Agreement.

4 PROGRAM REQUIREMENTS

4.1 Covered Populations and Services

4.1.1 Overview of Covered Populations

4.1.1.1 The MCO shall provide and be responsible for the cost of managed care services to population groups deemed by DHHS to be eligible for managed care and to be covered under the terms of this Agreement, as indicated in the table below.

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4.1.1.2 Members enrolled with the MCO who subsequently become ineligible for managed care during MCO enrollment shall be excluded from MCO participation. DHHS shall, based on State or federal statute, regulation, or policy, exclude other Members as appropriate.

Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Aid to the Needy Blind Non-Dual	X	
Aid to the Permanently and Totally Disabled Non-Dual	X	
American Indians and Alaskan Natives	X	
Auto Eligible and Assigned Newborns	X	
Breast and Cervical Cancer Program	X	
Children Enrolled in Special Medical Services/Partners in Health	X	
Children with Supplemental Security Income	X	
Family Planning Only Benefit		X
Foster Care/Adoption Subsidy	X	
Granite Advantage (Medicaid Expansion Adults, Frail/Non-Frail)	X	
Health Insurance Premium Payment		X
Home Care for Children with Severe Disabilities (Katie Beckett)	X	
In and Out Spend-Down		X
Medicaid Children Funded through the Children's Health Insurance Program	X	

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Member Category	Eligible for Managed Care	Not Eligible for Managed Care (DHHS Covered)
Medicaid for Employed Adults with Disabilities Non-Dual	X	
<u>[Amendment #5:] Medicaid for Employed Older Adults with Disabilities</u>	<u>X</u>	
Medicare Duals with full Medicaid Benefits	X	
Medicare Savings Program Only (no Medicaid services)		X
Members with Veterans Affairs Benefits		X
Non-Expansion Poverty Level Adults (Including Pregnant Women) and Children Non-Dual	X	
Old Age Assistance Non-Dual	X	
Retroactive/Presumptive Eligibility Segments (excluding Auto Eligible Newborns)		X
Third Party Coverage Non-Medicare, Except Members with Veterans Affairs Benefits	X	

4.1.2 Overview of Covered Services

4.1.2.1 The MCO shall cover the physical health, behavioral health, pharmacy, and other benefits for all MCO Members, as indicated in the summary table below and described in this Agreement. Additional requirements for Behavioral Health Services are included in Section 4.11 (Behavioral Health), and additional requirements for pharmacy are included in Section 4.2 (Pharmacy Management).

4.1.2.2 The MCO shall provide, at a minimum, all services identified in the following matrix, and all services in accordance with the CMS-approved Medicaid State Plan and Alternative Benefit Plan State Plan. The MCO shall cover services consistent with 45 CFR 92.207(b).

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4.1.2.3 While the MCO may provide a higher level of service and cover more services than required by DHHS (as described in Section 4.1.3 (Covered Services Additional Provisions), the MCO shall, at a minimum, cover the services identified at least up to the limits described in NH Code of Administrative Rules, chapter He-E 801, He-E 802, He-W 530, and He-M 426. DHHS reserves the right to alter this list at any time by providing reasonable notice to the MCO. [42 CFR 438.210(a)(1) and (2)]

4.1.2.3.1 [Amendment #6:] Covered home visiting services shall be consistent with State regulatory rules in effect.

Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Acquired Brain Disorder Waiver Services		X
Adult Medical Day Care	X	
Advanced Practice Registered Nurse	X	
Ambulance Service	X	
Ambulatory Surgical Center	X	
Audiology Services	X	
[Amendment #7] Intentionally Left Blank -Behavioral Health Crisis Treatment Center⁸	X	
Certified Non-Nurse Midwife	X	
Choices for Independence Waiver Services		X
Child Health Support Service – Division for Children, Youth & Families, except for services eligible under EPSDT		X

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Community Mental Health Services ⁹	X	
Crisis Intervention – Division for Children, Youth & Families		X
Developmental Disability Waiver Services		X
Dental Benefit Services ¹⁰		X
Designated Receiving Facilities	X	
Developmental Services Early Supports and Services		X
Early and Periodic Screening, Diagnostic and Treatment Services including Applied Behavioral Analysis Coverage	X	
Family Planning Services	X	
Freestanding Birth Centers	X	
Furnished Medical Supplies & Durable Medical Equipment	X	
Glenclyff Home		X
Home Based Therapy – Division for Children, Youth & Families		X
Home Health Services	X	
Home Visiting Services	X	

⁹ [Amendment #10] [Amendment #9] [Amendment #8:] [Amendment #7:] For the period July 1, 2021 through August 31, 2024 ~~June 30, 2023 June 30, December 31, 2022~~, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.

¹⁰ [Amendment #10:] Effective April 1, 2023, certain preventive, restorative, denture and other oral health services are carved-out of the MCM Program and covered under the State's contract with Delta Dental of New Hampshire, Inc. for eligible adults ages 21 years and over. Dental and oral health emergency services for Medicaid enrolled children and adults of all ages will continue to be Covered Services under the MCM Program.

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Hospice	X	
Home and Community-Based In Home Support Services		X
Inpatient Hospital	X	
Inpatient Hospital Swing Beds, Intermediate Care Facility		X
Inpatient Hospital Swing Beds, Skilled Nursing Facility		X
Inpatient Psychiatric Facility Services Under Age Twenty-One (21) ¹¹	X	
[Amendment #9:] [Amendment #8:] Inpatient Psychiatric Treatment in State-owned New Hampshire Hospital and Hampstead Hospital, and Other State Determined IMD for Mental Illness Inpatient Psychiatric Treatment in an Institution for Mental Disease, excluding New Hampshire Hospital ¹²	X	
Intensive Home and Community-Based Services– Division for Children, Youth & Families		X
Intermediate Care Facility Atypical Care		X
Intermediate Care Facility for Members with Intellectual Disabilities ¹³		X
Intermediate Care Facility Nursing Home		X
Laboratory (Pathology)	X	
Medicaid to Schools Services		X
Medical Services Clinic (e.g. Opioid Treatment Program)	X	

¹¹ Under age 22 if individual admitted prior to age 21

¹² [Amendment #9:] [Amendment #8:] Beginning July 1, 2022, Medicaid managed care inpatient psychiatric treatment at State-owned New Hampshire Hospital and Hampstead Hospital, and other State determined IMD for mental illness is covered up to sixty (60) days for adults age 21-64 due to a primary diagnosis of mental illness. Pursuant to 42-CFR-438.6 and 42-CFR-438.3(e)(2)(i) through (iii)

¹³ E.g., Cedarcrest

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Non-Emergency Medical Transportation ¹⁴	X	
Occupational Therapy ¹⁵	X	
Optometric Services Eyeglasses	X	
Outpatient Hospital ¹⁶	X	
<u>[Amendment #8:] Pediatric Residential Treatment Facility Services (effective September 1, 2019)</u>		X
Personal Care Services	X	
Physical Therapy ¹⁷	X	
Physicians Services	X	
Placement Services – Division for Children, Youth & Families		X
Podiatrist Services	X	
Prescribed Drugs	X	
Private Duty Nursing	X	
Private Non-Medical Institutional For Children – Division for Children, Youth & Families		X
Psychology	X	
<u>[Amendment #8:] Qualified Residential Treatment Program Services (effective September 1, 2019)</u>		X
Rehabilitative Services Post Hospital Discharge	X	

¹⁴ Also includes mileage reimbursement for Medically Necessary travel

¹⁵ Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services

¹⁶ Including facility and ancillary services for dental procedures

¹⁷ Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services

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Services	MCO Covered	Not Included in Managed Care (DHHS Covered)
Rural Health Clinic & Federally Qualified Health Centers	X	
Non-Swing Bed Skilled Nursing Facilities		X
Skilled Nursing Facilities Skilled Nursing Facilities Atypical Care		X
Speech Therapy ¹⁸	X	
Substance Use Disorder Services (Per He-W 513) – including services provided in Institutions for Mental Diseases pursuant to an approved 1115(a) research and demonstration waiver	X	
Transitional Housing Program Services and Community Residential Services With Wrap-Around Services and Supports ¹⁹	X	
Wheelchair Van	X	
X-Ray Services	X	

4.1.3 Covered Services Additional Provisions

4.1.3.1 Nothing in this Section 4.1.3 shall be construed to limit the MCO's ability to otherwise voluntarily provide any other services in addition to the services required to be provided under this Agreement.

4.1.3.2 The MCO shall seek written approval from DHHS, bear the entire cost of the service, and the utilization and cost of such voluntary services shall not be included in determining payment rates.

4.1.3.3 All services shall be provided in accordance with 42 CFR 438.210 and 42 CFR 438.207(b). The MCO shall ensure there is no disruption in service delivery to Members or Providers as the MCO transitions these services into Medicaid managed care from FFS.

¹⁸ Outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are limited to twenty (20) visits per benefit year for each type of therapy. Benefit limits are shared between habilitation services and outpatient rehabilitation services

¹⁹ [Amendment #6:] Beginning no earlier than Amendment #7 [Amendment #4:] Beginning on July 1, 2021 [Amendment #2:] July 1, 2020. [Base Contract:] Beginning on January 1, 2020.

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4.1.3.4 The MCO shall adopt written policies and procedures to verify that services are actually provided. [42 CFR 455.1(a)(2)]

4.1.3.5 In Lieu Of Services

4.1.3.5.1 [Amendment #10:] The MCO may provide Members with services or settings that are "In Lieu Of" Services or settings with prior approval and in accordance with federal regulations included in the Medicaid State Plan that are more medically appropriate, cost-effective substitutes for the Medicaid State Plan services. The MCO may cover In Lieu Of Services if:

4.1.3.5.1.1. Intentionally left blank DHHS determines that the alternative service or setting is a medically appropriate and cost-effective substitute;

4.1.3.5.1.2. Intentionally left blank The Member is not required to use the alternative service or setting;

4.1.3.5.1.3. Intentionally left blank The In Lieu Of Service has been authorized by DHHS; and

4.1.3.5.1.4. Intentionally left blank The in Lieu Of Service has been offered to Members at the option of the MCO. [42 CFR 438.3(e)(2)(i) - (iii)]

4.1.3.5.1.5. [Amendment #10:] Any In Lieu of Services on record prior to January 3, 2023 and proposed for continuation must comply with CMS federal regulations beginning January 1, 2024. [42 CFR 438.3(e)(2)(i) - (iii); SMDL 1/4/23]

4.1.3.5.2 [Amendment #10:] Intentionally left blank DHHS may determine that the alternative service or setting is a medically appropriate and cost-effective substitute by either: prospectively providing to the MCO a list of services that the MCO may consider In Lieu Of Services; or by the MCO receiving approval from DHHS to implement an In Lieu Of Service.

4.1.3.5.3 [Amendment #10:] Beginning September 1, 2019, DHHS has authorized medical nutrition, diabetes self-management, and assistance in finding and keeping housing (not including rent), as In Lieu Of Services. This list may be expanded upon or otherwise modified by DHHS through amendments of this Agreement. Previously authorized In Lieu Of Services are scheduled for review and modification as may be necessary to meet federal regulatory compliance effective January 1, 2024.

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4.1.3.5.4 [Amendment #10:] Intentionally left blank ~~For the MCO to obtain approval for In Lieu Of Services not authorized by DHHS, the MCO shall submit an In Lieu Of Service request to DHHS for each proposed In Lieu of Service not yet authorized.~~

4.1.3.5.5 [Amendment #10:] ~~The MCO shall support In Lieu of Services reporting~~ monitor the cost effectiveness of each approved In Lieu of Service by tracking utilization and expenditures and submit an annual update providing an evaluation of the cost effectiveness of the alternative service during the previous twelve (12) months, in accordance with federal regulations and Exhibit O.

4.1.3.6 [Amendment #8:] Intentionally Left Blank ~~Institution for Mental Diseases (IMD)~~

4.1.3.6.1 [Amendment #8:] Intentionally left blank. Pursuant to 42 CFR 438.6, the MCO shall pay for up to fifteen (15) inpatient days per calendar month for any Member who is receiving treatment in an IMD that is not a state owned or operated facility for the primary treatment of a psychiatric disorder.

4.1.3.6.2 [Amendment #8:] Intentionally left blank. The MCO shall not pay for any days in a given month if the Member exceeds fifteen (15) inpatient days for that month in an IMD that is not a state owned or operated facility, unless otherwise indicated by DHHS and permitted as a result of a federal waiver or other authority. The provision of inpatient psychiatric treatment in an IMD shall meet the requirements for In Lieu of Services at 42 CFR 438.3(e)(2)(i) (iii).

4.1.3.7 Telemedicine

4.1.3.7.1 The MCO shall comply with provisions of RSA 167:4(d) by providing access to telemedicine services to Members in certain circumstances.

4.1.3.7.2 The MCO shall develop a telemedicine clinical coverage policy and submit the policy to DHHS for review. Covered telemedicine modalities shall comply with all local, State and federal laws including the HIPAA and record retention requirements.

4.1.3.7.3 The clinical policy shall demonstrate how each covered telemedicine modality ensures security of PHI, including data security and encryption policies.

4.1.3.8 Non-Participating Indian Health Care Providers

4.1.3.8.1 American Indian/Alaska Native Members are permitted to obtain Covered Services from Non-Participating Indian Health

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Care Providers (IHCP) from whom the Member is otherwise eligible to receive such services. [42 CFR 438.14(b)(4)]

4.1.3.8.2 The MCO shall permit any American Indian/Alaska Native Member who is eligible to receive services from an IHCP PCP that is a Participating Provider, to choose that IHCP as their PCP, as long as that Provider has capacity to provide the services. [American Reinvestment and Recovery Act 5006(d); SMDL 10-001; 42 CFR 438.14(b)(3)]

4.1.3.9 Moral and Religious Grounds

4.1.3.9.1 An MCO that would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(a)(2)]

4.1.3.9.2 If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the MCO shall furnish information about the services it does not cover to DHHS with its application for a Medicaid contract and any time thereafter when it adopts such a policy during the Term of this Agreement. [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(b)(1)(i)(A)(1)-(2)]

4.1.3.9.3 If the MCO does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information on how and where to obtain such services, DHHS shall provide that information to potential Members upon request. [42 CFR 438.10(e)(2)(v)(C)]

4.1.4 Cost Sharing

4.1.4.1 Any cost sharing imposed on Medicaid Members shall be in accordance with NH's Medicaid Cost Sharing State Plan Amendment and Medicaid FFS requirements pursuant to 42 CFR 447.50 through 42 CFR 447.82. [Sections 1916(a)(2)(D) and 1916(b)(2)(D) of the Social Security Act; 42 CFR 438.108; 42 CFR 447.50 - 82; SMDL 6/16/06]

4.1.4.2 With the exception of Members who are exempt from cost sharing as described in the Medicaid Cost Sharing State Plan Amendment, the MCO shall require point of service (POS) Copayment for services for Members deemed by DHHS to have annual incomes at or above one hundred percent (100%) of the FPL as follows:

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4.1.4.2.1 A Copayment of one dollar (\$1.00) shall be required for each preferred prescription drug and each refill of a preferred prescription drug;

4.1.4.2.2 A Copayment of two dollars (\$2.00) shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug, unless the prescribing Provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the Copay for the non-preferred drug shall be one dollar (\$1.00);

4.1.4.2.3 A Copayment of one dollar (\$1.00) shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug; and

4.1.4.3 The following services are exempt from co-payments:

4.1.4.3.1 emergency services,

4.1.4.3.2 family planning services,

4.1.4.3.3 preventive services provided to children,

4.1.4.3.4 pregnancy-related services,

4.1.4.3.5 services resulting from potentially preventable events, and,

4.1.4.3.6 Cloramil (Clozapine) prescriptions. [42 CFR 447.56(a)]

4.1.4.4 Members are exempt from Copayments when:

4.1.4.4.1 The Member falls under the designated income threshold (one hundred percent (100%) or below the FPL);

4.1.4.4.2 The Member is under eighteen (18) years of age;

4.1.4.4.3 The Member is in a nursing facility or in an ICF for Members with IDs;

4.1.4.4.4 The Member participates in one (1) of the HCBS waiver programs;

4.1.4.4.5 The Member is pregnant and receiving services related to their pregnancy or any other medical condition that might complicate the pregnancy;

4.1.4.4.6 The Member is receiving services for conditions related to their pregnancy and the prescription is filled or refilled within sixty (60) calendar days after the month the pregnancy ended;

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4.1.4.4.7 The Member is in the Breast and Cervical Cancer Treatment Program;

4.1.4.4.8 The Member is receiving hospice care; or

4.1.4.4.9 The Member is an American Indian/Alaska Native.

4.1.4.5 Any American Indian/Alaskan Native who has ever received or is currently receiving an item or service furnished by an IHCP or through referral under contract health services shall be exempt from all cost sharing including Copayments and Premiums. [42 CFR 447.52(h); 42 CFR 447.56(a)(1)(x); ARRA 5006(a); 42 CFR 447.51(a)(2); SMDL 10-001]

4.1.5 Emergency Services

4.1.5.1 The MCO shall cover and pay for Emergency Services at rates that are no less than the equivalent DHHS FFS rates if the Provider that furnishes the services has an agreement with the MCO. [Section 1852(d)(2) of the Social Security Act; 42 CFR 438.114(b); 42 CFR 422.113(c)]

4.1.5.2 If the Provider that furnishes the Emergency Services does not have an agreement with the MCO, the MCO shall cover and pay for the Emergency Services in compliance with Section 1932(b)(2)(D) of the Social Security Act, 42 CFR 438.114(c)(1)(i), and the SMDL 3/20/98.

4.1.5.3 The MCO shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Participating Provider.

4.1.5.4 The MCO shall pay Non-Participating Providers of Emergency and Post-Stabilization Services an amount no more than the amount that would have been paid under the DHHS FFS system in place at the time the service was provided. [SMDL 3/31/06; Section 1932(b)(2)(D) of the Social Security Act]

4.1.5.5 The MCO shall not deny treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of Emergency Medical Condition.

4.1.5.6 The MCO shall not deny payment for treatment obtained when a representative, such as a Participating Provider, or the MCO instructs the Member to seek Emergency Services [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A) - (B)].

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4.1.5.7 The MCO shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

4.1.5.8 The MCO shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP, MCO, or DHHS of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. [42 CFR 438.114(d)(1)(i) - (ii)]

4.1.5.9 The MCO may not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. [42 CFR 438.114(d)(2)]

4.1.5.10 The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment. [42 CFR 438.114(d)(3)]

4.1.6 Post-Stabilization Services

4.1.6.1 Post-Stabilization Services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO shall be financially responsible for Post-Stabilization Services:

4.1.6.1.1 Obtained within or outside the MCO that are pre-approved by a Participating Provider or other MCO representative;

4.1.6.1.2 Obtained within or outside the MCO that are not pre-approved by a Participating Provider or other MCO representative, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services; and/or

4.1.6.1.3 Administered to maintain, improve or resolve the Member's stabilized condition without pre-authorization, and regardless of whether the Member obtains the services within the MCO network if:

4.1.6.1.3.1. The MCO does not respond to a request for pre-approval within one (1) hour;

4.1.6.1.3.2. The MCO cannot be contacted; or

4.1.6.1.3.3. The MCO representative and the treating physician cannot reach an agreement concerning the Member's care and an MCO physician is

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not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with an MCO physician, and the treating physician may continue with care of the patient until an MCO physician is reached or one (1) of the criteria of 42 CFR 422.133(c)(3) is met. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)-(ii); 422.113(c)(2)(iii)(A)-(C)]

4.1.6.2 The MCO shall limit charges to Members for Post-Stabilization Services to an amount no greater than what the organization would charge the Member if the Member had obtained the services through the MCO. [[42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)]

4.1.6.3 The MCO's financial responsibility for Post-Stabilization Services, if not pre-approved, ends when:

4.1.6.3.1 The MCO physician with privileges at the treating hospital assumes responsibility for the Member's care;

4.1.6.3.2 The MCO physician assumes responsibility for the Member's care through transfer;

4.1.6.3.3 The MCO representative and the treating physician reach an agreement concerning the Member's care; or

4.1.6.3.4 The Member is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i) - (iv)]

4.1.7 Value-Added Services

4.1.7.1 The MCO may elect to offer Value-Added Services that are not covered in the Medicaid State Plan or under this Agreement in order to improve health outcomes, the quality of care, or reduce costs, in compliance with 42 CFR 438.3(e)(i).

4.1.7.2 Value-Added Services are services that are not currently provided under the Medicaid State Plan. The MCO may elect to add Value-Added Services not specified in the Agreement at the MCO's discretion, but the cost of these Value-Added Services shall not be included in Capitation Payment calculations. The MCO shall submit to DHHS an annual list of the Value-Added Services being provided.

4.1.8 Early and Periodic Screening, Diagnostic, and Treatment

4.1.8.1 The MCO shall provide the full range of preventive, screening, diagnostic and treatment services including all medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions for EPSDT eligible beneficiaries ages

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birth to twenty-one in accordance with 1905(r) of the Social Security Act. [42 CFR 438.210(a)(5)]

4.1.8.2 The MCO shall determine whether a service is Medically Necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. Section 1396d(r), 42 CFR 438.210, and 42 CFR Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21, and the particular needs of the child and consistent with the definition for Medical Necessity included in this Agreement.

4.1.8.3 Upon conclusion of an individualized review of medical necessity, the MCO shall cover all Medically Necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. Section 1396d(a), regardless of whether such services are covered under the Medicaid State Plan and regardless of whether the request is labeled as such, with the exception of all services excluded from the MCO.

4.1.8.4 The MCO may provide Medically Necessary services in the most economic mode possible, as long as:

4.1.8.4.1 The treatment made available is similarly efficacious to the service requested by the Member's physician, therapist, or other licensed practitioner;

4.1.8.4.2 The determination process does not delay the delivery of the needed service; and

4.1.8.4.3 The determination does not limit the Member's right to a free choice of Participating Providers within the MCO's network.

4.1.8.5 Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services same day, or location of service) in the MCO clinical coverage policies, service definitions, or billing codes do not apply to Medicaid Members less than twenty-one (21) years of age, when those services are determined to be Medically Necessary per federal EPSDT criteria.

4.1.8.6 If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved per EPSDT criteria as Medically Necessary to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.

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4.1.8.7 The MCO shall not require Prior Authorization for Non-Symptomatic Office Visits (early and periodic screens/wellness visits) for Members less than twenty-one (21) years of age. The MCO may require Prior Authorization for other diagnostic and treatment products and services provided under EPSDT.

4.1.8.8 The MCO shall conduct Prior Authorization reviews using current clinical documentation, and shall consider the individual clinical condition and health needs of the child Member. The MCO shall not make an adverse benefit determination on a service authorization request for a Member less than twenty-one (21) years of age until the request is reviewed per EPSDT criteria.

4.1.8.9 While an EPSDT request is under review, the MCO may suggest alternative services that may be better suited to meet the Member's needs, engage in clinical or educational discussions with Members or Providers, or engage in informal attempts to resolve Member concerns as long as the MCO makes clear that the Member has the right to request authorization of the services he or she wants to request.

4.1.8.10 The MCO shall develop effective methods to ensure that Members less than twenty-one (21) years of age receive all elements of preventive health screenings recommended by the AAP in the Academy's most currently published Bright Futures preventive pediatric health care periodicity schedule using a validated screening tool. The MCO shall be responsible for requiring in contracts that all Participating Providers that are PCPs perform such screenings.

4.1.8.11 The MCO shall require that PCPs that are Participating Providers include all the following components in each medical screening:

4.1.8.11.1 Comprehensive health and developmental history that assesses for both physical and mental health, as well as for Substance Use Disorders;

4.1.8.11.2 Screening for developmental delay at each visit through the fifth (5th) year using a validated screening tool;

4.1.8.11.3 Screening for Autism Spectrum Disorders per AAP guidelines;

4.1.8.11.4 Comprehensive, unclothed physical examination;

4.1.8.11.5 All appropriate immunizations, in accordance with the schedule for pediatric vaccines, laboratory testing (including blood lead screening appropriate for age and risk factors); and

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4.1.8.11.6 Health education and anticipatory guidance for both the child and caregiver.

4.1.8.12 The MCO shall include the following information related to EPSDT in the Member Handbook:

4.1.8.12.1 The benefits of preventive health care;

4.1.8.12.2 Services available under the EPSDT program and where and how to obtain those services;

4.1.8.12.3 That EPSDT services are not subject to cost-sharing; and

4.1.8.12.4 That the MCO shall provide scheduling and transportation assistance for EPSDT services upon request by the Member.

4.1.8.13 The MCO shall perform outreach to Members who are due or overdue for an EPSDT screening service on a monthly basis.

4.1.8.13.1 The MCO shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed as a result of conditions disclosed during screenings and diagnosis.

4.1.8.14 The MCO shall submit its EPSDT plan for DHHS review and approval as part of its Readiness Review and in accordance with Exhibit O.

4.1.9 Non-Emergency Medical Transportation (NEMT)

4.1.9.1 The MCO shall arrange for the NEMT of its Members to ensure Members receive Medically Necessary care and services covered by the Medicaid State Plan regardless of whether those Medically Necessary Services are covered by the MCO.

4.1.9.1.1 ~~[Amendment #10:] [Amendment #7:] For the federal COVID-19 Public Health Emergency period beginning March 18, 2020, t~~The MCO shall assume medical necessity for coverage of a Member's NEMT covered service to a medical appointment originating from and returning to a nursing facility.

4.1.9.2 The MCO shall provide the most cost-effective and least expensive mode of transportation to its Members. However, the MCO shall ensure that a Member's lack of personal transportation is not a barrier of accessing care. The MCO and/or any Subcontractors shall be required to comply with all of the NEMT Medicaid State Plan requirements.

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4.1.9.3 The MCO shall ensure that its Members utilize a Family and Friends Mileage Reimbursement Program if they have a car, or a friend or family member with a car, who can drive them to their Medically Necessary service. A Member with a car who does not want to enroll in the Family and Friends Program shall meet one (1) of the following criteria to qualify for transportation services:

4.1.9.3.1 Does not have a valid driver's license;

4.1.9.3.2 Does not have a working vehicle available in the household;

4.1.9.3.3 Is unable to travel or wait for services alone; or

4.1.9.3.4 Has a physical, cognitive, mental or developmental limitation.

4.1.9.4 The MCO shall make good faith effort to achieve a fifty percent (50%) rate of total NEMT one-way rides provided by the MCO through the Family and Friends Mileage Reimbursement Program.

4.1.9.4.1 [Amendment #9:] Effective January 1, 2023, plus an additional ninety (90) day ramp up period to allow for related Member and vendor communications, the Family and Friends mileage reimbursement rate will increase to 62.5 cents per mile. The rate is based on the Internal Revenue Service (IRS) defined standard mileage rate effective on July 1, 2022.

4.1.9.5 If no car is owned or available, the Member shall use public transportation if:

4.1.9.5.1 The Member lives less than one half mile from a bus route;

4.1.9.5.2 The Provider is less than one half mile from the bus route; and

4.1.9.5.3 The Member is an adult under the age of sixty-five (65).

4.1.9.6 Exceptions the above public transportation requirement are:

4.1.9.6.1 The Member has two (2) or more children under age six (6) who shall travel with the parent;

4.1.9.6.2 The Member has one (1) or more children over age six (6) who has limited mobility and shall accompany the parent to the appointment; or

4.1.9.6.3 The Member has at least one (1) of the following conditions:

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- 4.1.9.6.3.1. Pregnant or up to six (6) weeks post-partum,
- 4.1.9.6.3.2. Moderate to severe respiratory condition with or without an oxygen dependency,
- 4.1.9.6.3.3. Limited mobility (walker, cane, wheelchair, amputee, etc.),
- 4.1.9.6.3.4. Visually impaired,
- 4.1.9.6.3.5. Developmentally delayed,
- 4.1.9.6.3.6. Significant and incapacitating degree of mental illness, or
- 4.1.9.6.3.7. Other exception by Provider approval only.

4.1.9.7 If public transportation is not an option, the MCO shall ensure that the Member is provided transportation from a transportation Subcontractor.

4.1.9.7.1 [Amendment #7:] For NEMT driver services delivered on or after December 21, 2021, excluding public transit drivers, the MCO shall ensure: ~~The MCO shall be required to perform background checks on all non-emergency medical transportation providers and/or Subcontractors.~~

4.1.9.7.1.1. [Amendment #7:] Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

4.1.9.7.1.2. [Amendment #7:] Each such individual driver has a valid driver's license;

4.1.9.7.1.3. [Amendment #7:] Each such provider has in place a process to address any violation of a state drug law; and

4.1.9.7.1.4. [Amendment #7:] Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider. [Consolidated Appropriations Act, 2021 (Public Law 116-260), Division CC, Title II, Section 209].

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4.1.9.8 The MCO shall assure that ninety-five percent (95%) of all Member scheduled rides for non-methadone services are delivered within fifteen (15) minutes of the scheduled pick-up time.

4.1.9.9 The MCO shall provide reports to DHHS related to NEMT requests, authorizations, trip results, service use, late rides, and cancellations, in accordance with Exhibit O.

4.2 Pharmacy Management

4.2.1 MCO and DHHS Covered Prescription Drugs

4.2.1.1 The MCO shall cover all outpatient drugs where the manufacturer has entered into the federal rebate agreement and for which DHHS provides coverage as defined in Section 1927(k)(2) of the Social Security Act [42 CFR 438.3(s)(1)], with the exception of select drugs for which DHHS shall provide coverage to ensure Member access as identified by DHHS in separate guidance. The MCO shall not include drugs by manufacturers not participating in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) Medicaid rebate program on the MCO formulary without DHHS consent.

4.2.1.2 The MCO shall pay for all prescription drugs – including specialty and office administered drugs, with the exception of those specifically indicated by DHHS as not covered by the MCO in separate guidance – consistent with the MCO's formulary and pharmacy edits and Prior Authorization criteria that have been reviewed and approved by DHHS, and are consistent with the DHHS Preferred Drug List (PDL) as described in Section 4.2.2 (MCO Formulary) below.

4.2.1.3 Current Food and Drug Administration (FDA)-approved specialty, bio-similar and orphan drugs, and those approved by the FDA in the future, shall be covered in their entirety by the MCO, unless such drugs are specified in DHHS guidance as covered by DHHS.

4.2.1.4 The MCO shall pay for, when Medically Necessary, orphan drugs that are not yet approved by the FDA for use in the United States but that may be legally prescribed on a "compassionate-use basis" and imported from a foreign country.

4.2.1.5 [Amendment #7:] Effective no later than April 1, 2022, the MCO shall ensure Members diagnosed with opioid use disorder, substance use disorder, and behavioral health conditions treated at CMH Program, FQHC, FQHC look-alike, and Doorway network

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facilities with integrated on-site pharmacies have immediate access to covered specialty drugs to treat related conditions.

4.2.2 MCO Formulary

4.2.2.1 DHHS shall establish the PDL and shall be the sole party responsible for negotiating rebates for drugs on the PDL.

4.2.2.2 The MCO shall use DHHS's PDL and shall not negotiate any drug rebates with pharmaceutical manufacturers for prescribed drugs on the PDL.

4.2.2.3 DHHS shall be responsible for invoicing any pharmaceutical manufacturers for federal rebates mandated under federal law and for PDL supplemental rebates negotiated by DHHS.

4.2.2.4 The MCO shall develop a formulary that adheres to DHHS's PDL for drug classes included in the PDL and is consistent with Section 4.2.1 (MCO and DHHS Covered Prescription Drugs). In the event that DHHS makes changes to the PDL, DHHS shall notify the MCO of the change and provide the MCO with 30 calendar days to implement the change.

4.2.2.5 Negative changes shall apply to new starts within thirty (30) calendar days of notice from DHHS. The MCO shall have ninety (90) calendar days to notify Members and prescribers currently utilizing medications that are to be removed from the PDL if current utilization is to be transitioned to a preferred alternative.

4.2.2.6 For any drug classes not included in the DHHS PDL, the MCO shall determine the placement on its formulary of products within that drug class, provided the MCO covers all products for which a federal manufacturer rebate is in place and the MCO is in compliance with all DHHS requirements in this Agreement.

4.2.2.7 DHHS shall maintain a uniform review and approval process through which the MCO may submit additional information and/or requests for the inclusion of additional drug or drug classes on the DHHS PDL. DHHS shall invite the MCO's Pharmacy Manager to attend meetings of the NH Medicaid DUR Board.

4.2.2.8 The MCO shall make an up-to-date version of its formulary available to all Participating Providers and Members through the MCO's website and electronic prescribing tools. The formulary shall be available to Members and Participating Providers electronically, in a machine-readable file and format, and shall, at minimum, contain information related to:

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4.2.2.8.1 Which medications are covered, including whether it is the generic and/or the brand drug; and

4.2.2.8.2 What tier each medication is on. [42 CFR 438.10(i)(1) - (3)]

4.2.2.9 The MCO shall adhere to all relevant State and federal law, including without limitation, with respect to the criteria regarding coverage of non-preferred formulary drugs pursuant to Chapter 188, laws of 2004, Senate Bill 383-FN, Sect. IVa. A Member shall continue to be treated or, if newly diagnosed, may be treated with a non-preferred drug based on any one (1) of the following criteria:

4.2.2.9.1 Allergy to all medications within the same class on the PDL;

4.2.2.9.2 Contraindication to or drug-to-drug interaction with all medications within the same class on the PDL;

4.2.2.9.3 History of unacceptable or toxic side effects to all medications within the same class on the PDL;

4.2.2.9.4 Therapeutic failure of all medications within the same class on the PDL;

4.2.2.9.5 An indication that is unique to a non-preferred drug and is supported by peer-reviewed literature or a unique federal FDA-approved indication;

4.2.2.9.6 An age-specific indication;

4.2.2.9.7 Medical co-morbidity or other medical complication that precludes the use of a preferred drug; or;

4.2.2.9.8 Clinically unacceptable risk with a change in therapy to a preferred drug. Selection by the physician of the criteria under this subparagraph shall require an automatic approval by the pharmacy benefit program.

4.2.3 Clinical Policies and Prior Authorizations

4.2.3.1 The MCO, including any pharmacy Subcontractors, shall establish a pharmacy Prior Authorization program that includes Prior Authorization criteria and other POS edits (such as prospective DUR edits and dosage limits), and complies with Section 1927(d)(5) of the Social Security Act [42 CFR 438.3(s)(6)] and any other applicable State and federal laws, including House Bill 517, as further described in Section 4.11.1.15 (Prior Authorization).

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4.2.3.2 The MCO's pharmacy Prior Authorization criteria, including any pharmacy policies and programs, shall be submitted to DHHS prior to the implementation of this Agreement, shall be subject to DHHS approval, and shall be submitted to DHHS prior to the MCO's implementation of a modification to the criteria, policies, and/or programs.

4.2.3.3 The MCO's pharmacy Prior Authorization criteria shall meet the requirements related to Substance Use Disorder, as outlined in Section 4.11.6.15 (Limitations on Prior Authorization Requirements) of this Agreement. Under no circumstances shall the MCO's Prior Authorization criteria and other POS edits or policies depart from these requirements.

4.2.3.3.1 Additionally, specific to Substance Use Disorder, the MCO shall offer a pharmacy mail order opt-out program that is designed to support Members in individual instances where mail order requirements create an unanticipated and unique hardship. The opt-out program shall not apply to specialty pharmacy.

4.2.3.3.2 The MCO shall conduct both prospective and retrospective DUR for all Members receiving MAT for Substance Use Disorder to ensure that Members are not receiving opioids and/or benzodiazepines from other health care Providers while receiving MAT.

4.2.3.3.3 The retrospective DUR shall include a review of medical claims to identify Members that are receiving MAT through physician administered drugs (such as methadone, vivitrol, etc.).

4.2.3.4 The MCO shall make available on its website information regarding any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the DHHS-approved modification effective date.

4.2.3.5 Further, the MCO shall notify all Members and Participating Providers impacted by any modifications to the MCO's pharmacy Prior Authorization criteria, pharmacy policies, and pharmacy programs no less than thirty (30) calendar days prior to the DHHS-approved modification effective date.

4.2.3.6 [Amendment #2:] The MCO shall implement and operate a DUR program that shall be in compliance with Section 1927(g) of the Social Security Act, address Section 1004 provisions of the SUPPORT for Patient and Communities Act, and include:

4.2.3.6.1 Prospective DUR;

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4.2.3.6.2 Retrospective DUR; and

4.2.3.6.3 [Amendment #2:] An educational program for Participating Providers, including prescribers and dispensers; and. [42 CFR 456, subpart K; 42 CFR 438.3(e)(4)]

4.2.3.6.4 [Amendment #2:] DUR program features in accordance with Section 1004 provisions of the SUPPORT for Patient and Communities Act, including:

4.2.3.6.4.1. [Amendment #2:] Safety edit on days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates fills of opioids in excess of limitations identified by the State;

4.2.3.6.4.2. [Amendment #2:] Safety edits on the maximum daily morphine equivalent for treatment of pain and a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;

4.2.3.6.4.3. [Amendment #2:] A claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

4.2.3.6.4.4. [Amendment #2:] A program to monitor and manage the appropriate use of antipsychotic medications by all children including foster children enrolled under the State plan;

4.2.3.6.4.5. [Amendment #2:] Fraud and abuse identification processes that identifies potential fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies; and

4.2.3.6.4.6. [Amendment #2:] Operate like the State's Fee-for-Service DUR program. [42 CFR 456, subpart K; 42 CFR 438.3(s)(4)].

4.2.3.7 The MCO shall submit to DHHS a detailed description of its DUR program prior to the implementation of this Agreement and, if the MCO's DUR program changes, annually thereafter.

4.2.3.7.1 In accordance with Section 1927 (d)(5)(A) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request

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for Prior Authorization one hundred percent (100%) of the time and reimburse for the dispensing of at least a seventy two (72) hour supply of a covered outpatient prescription drug in an emergency situation when Prior Authorization cannot be obtained. [42 CFR 438.210(d)(3)]

4.2.3.8 The MCO shall develop and/or participate in other State of New Hampshire pharmacy-related quality improvement initiatives, as required by DHHS and in alignment with the MCO's QAPI, further described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

4.2.3.8.1 [Amendment #8:] Beginning with calendar year 2022, for the HEDIS Measure "Use of Opioids from Multiple Providers", the MCO shall achieve performance that is less than or equal to the average rate of New England HMO Medicaid health plans as reported by NCQA Quality Compass for the previous calendar year.

4.2.3.9 The MCO shall institute a Pharmacy Lock-In Program for Members, which has been reviewed by DHHS, and complies with requirements included in Section 4.11.6.15 (Limitations on Prior Authorization Requirements). If the MCO determines that a Member meets the Pharmacy Lock-In criteria, the MCO shall be responsible for all communications to Members regarding the Pharmacy Lock-In determination. The MCO may, provided the MCO receives prior approval from DHHS, implement Lock-In Programs for other medical services.

4.2.3.10 [Amendment #6:] Members shall not be required to change covered prescription drugs more than once per calendar year, with the following exceptions:

4.2.3.10.1 [Amendment #6:] When a Member is new to Medicaid, or switches from one Medicaid MCO to another Medicaid MCO;

4.2.3.10.2 [Amendment #6:] When a covered prescription drug change is initiated by the Member's provider;

4.2.3.10.3 [Amendment #6:] When a biosimilar becomes available to the market;

4.2.3.10.4 [Amendment #6:] When FDA boxed warnings or new clinical guidelines are recognized by CMS;

4.2.3.10.5 [Amendment #6:] When a covered prescription drug is withdrawn from the market because it has been found to be unsafe or removed for another reason; and

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4.2.3.10.6 [Amendment #6:] When a covered prescription is not available due to a supply shortage.

4.2.4 Systems, Data, and Reporting Requirements

4.2.4.1 Systems Requirements

4.2.4.1.1 The MCO shall adjudicate pharmacy claims for its Members using a POS system where appropriate. System modifications include, but are not limited to:

4.2.4.1.1.1. Systems maintenance,

4.2.4.1.1.2. Software upgrades, and

4.2.4.1.1.3. National Drug Code sets, or migrations to new versions of National Council for Prescription Drug Programs (NCPDP).

4.2.4.1.2 Transactions shall be updated and maintained to current industry standards. The MCO shall provide an automated determination during the POS transaction; in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds.

4.2.4.2 Data and Reporting Requirements

4.2.4.2.1 To demonstrate its compliance with the DHHS PDL, the MCO shall submit to DHHS information regarding its PDL compliance rate.

4.2.4.2.2 In accordance with changes to rebate collection processes in the Affordable Care Act, DHHS shall be responsible for collecting OBRA 90 CMS rebates, inclusive of supplemental, from drug manufacturers on MCO pharmacy claims.

4.2.4.2.3 [Amendment #2:] The MCO shall provide all necessary pharmacy Encounter Data to the State to support the rebate billing process and the MCO shall submit the Encounter Data file within ~~seven (7)~~ fourteen (14) calendar days of claim payment. The Encounter Data and submission shall conform to all requirements described in Section 5.1.3 (Encounter Data) of this Agreement.

4.2.4.2.4 The drug utilization information reported to DHHS shall, at a minimum, include information on:

4.2.4.2.4.1. The total number of units of each dosage form,

4.2.4.2.4.2. Strength, and

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4.2.4.2.4.3. Package size by National Drug Code of each covered outpatient drug dispensed, per DHHS encounter specifications. [42 CFR 438.3(s)(2); Section 1927(b) of the Social Security Act]

4.2.4.2.5 The MCO shall establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization reports provided to DHHS. [42 CFR 438.3(s)(3)]

4.2.4.2.6 The MCO shall implement a mechanism to prevent duplicate discounts in the 340B Drug Pricing Program.

4.2.4.2.7 The MCO shall work cooperatively with the State to ensure that all data needed for the collection of CMS and supplemental rebates by the State's pharmacy benefit administrator is delivered in a comprehensive and timely manner, inclusive of any payments made for Members for medications covered by other payers.

4.2.4.2.8 The MCO shall adhere to federal regulations with respect to providing pharmacy data required for DHHS to complete and submit to CMS the Annual Medicaid DUR Report. [42 CFR 438.3(s)(4),(5)]

4.2.4.2.9 The MCO shall provide DHHS reporting regarding pharmacy utilization, polypharmacy, authorizations and the Pharmacy Lock-In Program, medication management, and safety monitoring of psychotropics in accordance with Exhibit O.

4.2.4.2.10 The MCO shall provide to DHHS detailed information regarding providing PCPs and behavioral health Providers access to their patients' pharmacy data and for providing prescriber information to the State PDMP. This data shall be provided in a manner prescribed by DHHS as permitted by State and federal law.

4.2.5 Medication Management

4.2.5.1 Medication Management for All Members

4.2.5.1.1 [Amendment #5:] The MCO shall at least annually conduct Comprehensive Medication Review (CMR) and counseling by a pharmacist or other health care professional to adult and child Members with ~~polypharmacy~~ in accordance with separate guidance.

4.2.5.1.2 In the event the Member does not respond to the MCO's offer to provide medication review and counseling, the MCO shall continue to attempt to provide such services to the Member at least

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monthly or until the Member actively accepts or denies receipt of Medication Management Services.

4.2.5.1.2.1. [Amendment #5:] The MCO shall provide comprehensive medication review and counseling to any Member upon request.

4.2.5.1.3 Polypharmacy is defined as:

4.2.5.1.3.1. Adult members dispensed five (5) or more maintenance drugs based on Generic Product Identifier (GPI) 10 or an equivalent product identification code over a sixty (60) day period (or the equivalent of five (5) maintenance drugs over a sixty (60) day period, for drugs dispensed for several months at a time); and

4.2.5.1.3.2. Child members dispensed four (4) or more maintenance drugs based on GPI 10 or an equivalent product identification code over a sixty (60) day period (or the equivalent of four (4) maintenance drugs over a sixty (60) day period, for drugs dispensed for several months at a time).

4.2.5.1.4 CMR is defined as a systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber. The counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider and is designed to improve patients' knowledge of their prescriptions, over-the-counter medications, herbal therapies and dietary supplements, identify and address problems or concerns that patients may have, and empower patients to self-manage their medications and their health conditions.

4.2.5.1.5 The MCO shall routinely monitor and address the appropriate use of behavioral health medications in children by encouraging the use of, and reimbursing for consultations with, child psychiatrists.

4.2.5.1.6 The MCO may, for purposes of satisfying Medication Management requirements, permit a Subcontract with retail-dispensing pharmacist(s) or another alternative that is also an appropriately credentialed and licensed professional approved by DHHS as part of a medication therapy management program,

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provided that the MCO ensures that the retail-dispensing pharmacist or approved alternative has access to all Member dispensing information, the MCO retains final oversight and accountability, and the MCO receives DHHS review prior to implementation of the program.

4.2.5.2 Medication Management for Children with Special Health Care Needs

4.2.5.2.1 The MCO shall be responsible for active and comprehensive medication management for Children with Special Health Care Needs. The MCO shall offer to Members, their parents, and/or caregivers, comprehensive medication management services for Children with Special Health Care Needs. If comprehensive medication management services for Children with Special Health care Needs are accepted, the MCO shall develop active and comprehensive medication management protocols for Children with Special Health Care Needs that shall include, but not be limited to, the following:

4.2.5.2.1.1. Performing or obtaining necessary health assessments;

4.2.5.2.1.2. Formulating a medication treatment plan according to therapeutic goals agreed upon by prescriber and the Member, parent and caregiver;

4.2.5.2.1.3. Selecting, initiating, modifying, recommending changes to, or administering medication therapy;

4.2.5.2.1.4. Monitoring, which could include lab assessments and evaluating Member's response to therapy;

4.2.5.2.1.5. Consulting with social service agencies on medication management services;

4.2.5.2.1.6. Initial and on-going CMR to prevent medication-related problems and address drug reconciliation, including adverse drug events, followed by targeted medication reviews;

4.2.5.2.1.7. Documenting and communicating information about care delivered to other appropriate health care Providers;

4.2.5.2.1.8. Member education to enhance understanding and appropriate use of medications; and

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4.2.5.2.1.9. Coordination and integration of medication therapy management services with broader health Care Management services to ensure access to Medically Necessary medications wherever Member is placed, including access to out of network pharmacies.

4.2.5.2.1.10. Review of medication use shall be based on the following:

- 4.2.5.2.1.10.1 Pharmacy claims;
- 4.2.5.2.1.10.2 Provider progress reports;
- 4.2.5.2.1.10.3 Comprehensive Assessments and care plans;
- 4.2.5.2.1.10.4 Contact with the Member's Providers;
- 4.2.5.2.1.10.5 Current diagnoses;
- 4.2.5.2.1.10.6 Current behavioral health functioning;
- 4.2.5.2.1.10.7 Information from the family, Provider, DHHS and residential or other treatment entities or Providers; and
- 4.2.5.2.1.10.8 Information shared, to the extent permissible by State and federal law, with DCYF around monitoring and managing the use of psychotropic medications for children in State custody/guardianship.

4.3 Member Enrollment and Disenrollment

4.3.1 Eligibility

4.3.1.1 DHHS has sole authority to determine whether an individual meets the eligibility criteria for Medicaid as well as whether the individual shall be enrolled in the MCM program. The MCO shall comply with eligibility decisions made by DHHS.

4.3.1.2 The MCO and its Subcontractors shall ensure that ninety-nine percent (99%) of transfers of eligibility files are incorporated and updated within one (1) business day after successful receipt of data. The MCO shall develop a plan to ensure the provision of pharmacy benefits in the event the eligibility file is not successfully loaded. The MCO shall make DHHS aware, within one (1) business day, of unsuccessful uploads that go beyond twenty-four (24) hours.

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4.3.1.3 The Accredited Standards Committee (ASC) X12 834 enrollment file shall limit enrollment history to eligibility spans reflective of any assignment of the Member with the MCO.

4.3.1.4 To ensure appropriate Continuity of Care, DHHS shall provide up to six (6) months (as available) of all FFS paid claims history including: medical, pharmacy, behavioral health and LTSS claims history data for all FFS Medicaid Members assigned to the MCO. For Members transitioning from another MCO, DHHS shall also provide such claims data as well as available encounter information regarding the Member supplied by other MCOs.

4.3.1.5 The MCO shall notify DHHS within five (5) business days when it identifies information in a Member's circumstances that may affect the Member's eligibility, including changes in the Member's residence, such as out-of-state claims, or the death of the Member. [42 CFR 438.608(a)(3)]

4.3.1.6 [Amendment #5:] In accordance with separate guidance, the MCO shall outreach to Members thirty (30) calendar days prior to each Member's Medicaid eligibility expiration date to assist the Member with completion and submission of required paperwork. The MCO shall be required to submit their outbound call protocols for DHHS review during the Readiness Review process.

4.3.1.6.1 [Amendment #5:] In accordance with separate guidance, the MCO shall provide support to unwind the Public Health Emergency as may be requested.

4.3.1.6.1.1. [Amendment #8:] The MCO shall take reasonable steps to support its Members prior to and during the Public Health Emergency continuous enrollment unwind period to maintain coverage for eligible beneficiaries, and promote smooth transitions for Members no longer eligible for Medicaid or other coverage.

4.3.1.6.1.2. [Amendment #8:] The MCO shall not conduct outreach to address the backlog of pending Medicaid eligibility cases to Members in a manner that would constitute a violation of federal law, including, but not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Further, compliance with these laws includes providing reasonable

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accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits. [CMS State Health Official Letter, SHO #22-001; Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency. March 3, 2022]

4.3.2 [Amendment #3:] Intentionally Left Blank

[Amendment #3:] MCO Role in Work and Community Engagement Requirements for Granite Advantage Members

~~4.3.2.1 [Amendment #3:] The MCO shall support the implementation and ongoing operations of the work and community engagement eligibility requirements for certain Granite Advantage Members, including but not limited to the activities described in Section 4.3.3 (General Outreach and Member Education Activities) through 4.3.3.2.3 (Status Tracking and Targeted Outreach) of this Agreement.~~

4.3.3 [Amendment #3:] Intentionally Left Blank

[Amendment #3:] General Outreach and Member Education Activities

~~4.3.3.1 [Amendment #3:] The MCO shall provide general outreach and education to Granite Advantage Members regarding work and community engagement requirements set forth in the Granite Advantage waiver program and State administrative rules. MCO responsibilities include the following:~~

~~4.3.3.1.1 [Amendment #3:] The MCO shall require that Member Services staff participate in DHHS training on work and community engagement requirements;~~

~~4.3.3.1.2 [Amendment #3:] The MCO shall modify all Member Services call center scripts and Member Handbooks to provide information and assistance related to work and community engagement requirements;~~

~~4.3.3.1.3 [Amendment #3:] In instances in which a Granite Advantage Member contacts the MCO for any reason, the MCO shall:~~

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- 4.3.3.1.3.1. ~~[Amendment #3:] Inquire as to the Member's awareness of the community engagement requirement;~~
- 4.3.3.1.3.2. ~~[Amendment #3:] Inquire as to the Member's awareness of frailty and other exemptions;~~
- 4.3.3.1.3.3. ~~[Amendment #3:] Inquire as to the Member's awareness of their exemption status;~~
- 4.3.3.1.3.4. ~~[Amendment #3:] Inquire as to the Member's awareness of qualifying activities and good cause exemptions if the Member's community engagement participation is mandatory;~~
- 4.3.3.1.3.5. ~~[Amendment #3:] Explain how to satisfy the community engagement requirements, including the reporting requirements if the Member's community engagement participation is mandatory;~~
- 4.3.3.1.3.6. ~~[Amendment #3:] Coordinate with DHHS to directly connect the Granite Advantage Member to DHHS after speaking with DHHS to accept the call ("warm transfer"); and~~
- 4.3.3.1.3.7. ~~[Amendment #3:] Report these activities in accordance with Exhibit O.~~
- 4.3.3.1.4 ~~[Amendment #3:] The MCO shall participate in and support additional outreach and education initiatives related to work and community engagement requirements for Granite Advantage Members as defined by DHHS.~~
- 4.3.3.2 ~~[Amendment #3:] Member Support Services~~
 - 4.3.3.2.1 ~~[Amendment #3:] The MCO shall provide Granite Advantage Members with support related to work and community engagement requirements, including:~~
 - 4.3.3.2.1.1. ~~[Amendment #3:] Assistance with DHHS processes for reporting compliance, obtaining good cause or other exemptions; in the event a Member contacts the MCO seeking to report his/her compliance with work requirements or obtain a good cause or other exemption, the MCO shall help the Member navigate DHHS's process for demonstrating such compliance and/or exemption;~~

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~~4.3.3.2.1.2. [Amendment #3:] Connection to other sources of coverage, when applicable: As indicated in the Special Terms and Conditions of the Granite Advantage waiver approved by CMS, in the event the Member becomes ineligible for Medicaid coverage due to the work requirement, the MCO is required to support the State in the screening of eligibility for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 435.016(f).~~

~~4.3.3.2.1.3. [Amendment #3:] Providing Information on options for Members to satisfy the work and community engagement requirements.~~

~~4.3.3.2.2 [Amendment #3:] Identification of Exempt or Potentially Exempt Members~~

~~4.3.3.2.2.1. [Amendment #3:] The MCO shall notify DHHS, through a mechanism specified by DHHS, of any Granite Advantage Members that the MCO identifies as potentially exempt.~~

~~4.3.3.2.2.2. [Amendment #3:] The MCO shall conduct analyses of claims and Encounter Data to identify Granite Advantage Members who may be exempt from work and community engagement requirements as defined by the Granite Advantage waiver program.~~

~~4.3.3.2.2.3. [Amendment #3:] The MCO shall conduct claims analysis for all Granite Advantage Members on an ongoing basis, at the frequency defined by DHHS. The MCO shall review all sources of data that may support its understanding of Granite Advantage Members' status related to work and community engagement requirements, including but not limited to:~~

~~4.3.3.2.2.3.1 [Amendment #3:] Information regarding Members' hospitalization;~~

~~4.3.3.2.2.3.2 [Amendment #3:] Information regarding Members' diagnoses and conditions; and~~

~~4.3.3.2.2.3.3 [Amendment #3:] Information regarding any circumstances that would exempt or potentially exempt a Member from being subject to work and community engagement requirements.~~

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~~4.3.3.2.2.4. [Amendment #3:] The MCO shall also monitor its Care Management systems and the Admissions, Discharge and Transfers (ADT) feed, and as applicable monitor its Subcontractors' Care Management system(s), for hospitalizations, diagnoses, or indications of circumstances that would exempt or potentially exempt Granite Advantage Members from work and community engagement requirements.~~

~~4.3.3.2.2.5. [Amendment #3:] For Granite Advantage Members identified as potentially exempt from work and community engagement requirements based on the MCO's claims and Encounter Data analysis, the MCO shall attempt to support the Member in obtaining physician certification of the exemption.~~

~~4.3.3.2.2.6. [Amendment #3:] The MCO shall transmit to DHHS, through a mechanism to be specified by DHHS, information for Members who are exempt or may be exempt.~~

~~4.3.3.2.2.7. [Amendment #3:] The MCO shall indicate to DHHS that the Granite Advantage Member is potentially exempt from work and community engagement requirements if, based on the MCO's claims analysis, physician certification, and/or Care Management data, the MCO can determine that the Member is exempt.~~

~~4.3.3.2.2.8. [Amendment #3:] The MCO shall indicate that the Member is potentially exempt if the MCO has determined that the individual meets the criteria for a diagnosis based exemption, but the MCO has not been able to obtain the required physician certification.~~

~~4.3.3.2.3 [Amendment #3:] Status Tracking and Targeted Outreach~~

~~4.3.3.2.3.1. [Amendment #3:] The MCO shall receive from DHHS information generated via electronic file related to Granite Advantage Members' work and community engagement requirement status; for example, this information will indicate that the Granite Advantage Member is either "exempt," "mandatory compliant," or "mandatory non-compliant" with the work and community engagement requirements. The MCO~~

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~~shall be able to receive and process new information in the format designated by DHHS.~~

~~4.3.3.2.4 [Amendment #3:] For Granite Advantage Members identified by DHHS as "mandatory non-compliant," the MCO shall perform targeted outreach activities and provide assistance designed to support the Member in becoming compliant with requirements to avoid coverage suspension or termination, as specified by DHHS.~~

~~4.3.3.2.5 [Amendment #3:] The MCO's outreach to "mandatory non-compliant" Granite Advantage Members shall include, but is not limited to:~~

~~4.3.3.2.5.1. [Amendment #3:] Telephonic outreach, including outreach above and beyond the initial Member welcome call;~~

~~4.3.3.2.5.2. [Amendment #3:] Distribution of DHHS-approved mailings or other educational materials; and/or~~

~~4.3.3.2.5.3. [Amendment #3:] Transmittal of electronic notification(s), including text messaging.~~

~~4.3.3.2.6 [Amendment #3:] During periods of Member suspension of eligibility due to non-compliance with community engagement requirements or failure to receive an exemption, the MCO shall continue outreach to the suspended Member to assist the Member in completing requirements during the period before final termination of the Member's eligibility.~~

4.3.4 Enrollment

4.3.4.1 Pursuant to 42 CFR 438.54, Members who do not select an MCO as part of the Medicaid application process shall be auto-assigned to an MCO. All newly eligible Medicaid Members shall be given ninety (90) calendar days to either remain in the assigned MCO or select another MCO, if they choose. Members may not change from one (1) MCO to another outside the ninety (90) day plan selection period unless they meet the "cause" criteria as described in Section 4.3.7 (Disenrollment) of this Agreement.

4.3.4.2 The MCO shall accept all Members who choose to enroll in or who were assigned to the MCO by DHHS. The MCO shall accept for automatic re-enrollment Members who were disenrolled due to a loss of Medicaid eligibility for a period of two (2) months or less. [42 CFR 438.56(g)]

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4.3.4.2.1 [Amendment #8:] Beginning July 1, 2022, the MCO shall accept temporarily auto re-enrolled Members into their managed care plan after the individual's loss of Medicaid coverage for a period of 120 days or less. The temporary auto re-enrollment mechanism shall remain effective until 17 months after the end of the month in which the public health emergency for COVID-19 ends as declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. § 247d). [Section 1902(e)(14) of the Act]

4.3.4.3 The MCO shall permit each Member to choose a PCP to the extent possible and appropriate. [42 CFR 438.3(l)] In instances in which the Member does not select a PCP at the time of enrollment, the MCO shall assign a PCP to the Member.

4.3.4.4 When assigning a PCP, the MCO shall include the following methodology, if information is available: Member claims history; family member's Provider assignment and/or claims history; geographic proximity; special medical needs; and language/cultural preference.

4.3.5 Non-Discrimination

4.3.5.1 The MCO shall accept new enrollment from individuals in the order in which they apply, without restriction, unless authorized by CMS. [42 CFR 438.3(d)(1)]

4.3.5.2 The MCO shall not discriminate against eligible persons or Members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions. [42 CFR 438.3(d)(3)]

4.3.5.3 The MCO shall not discriminate in enrollment, disenrollment, and re-enrollment against individuals on the basis of health status or need for health care services. [42 CFR 438.3(q)(4)]

4.3.5.4 The MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and shall not use any policy or practice that has a discriminatory effect. [42 CFR 438.3(d)(4)]

4.3.5.5 In accordance with RSA 354-A and all other relevant State and federal laws, the MCO shall not discriminate on the basis of gender identity.

4.3.6 Auto-Assignment

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4.3.6.1 [Amendment #9:] In its sole discretion, DHHS shall consider Opioid Treatment Program (OTP) resolution before using ~~use~~ the following factors for auto-assignment ~~in an order to be determined by DHHS:~~

4.3.6.1.1 Preference to an MCO with which there is already a family affiliation;

4.3.6.1.2 Previous MCO enrollment, when applicable;

4.3.6.1.3 [Amendment #5:] Provider-Member relationship, to the extent obtainable and pursuant to 42 CFR 438 54(d)(7); and

4.3.6.1.4 [Amendment #5:] Any members earned through the Performance-Based Auto-Assignment Program; and

4.3.6.1.5 [Amendment #5:] Equitable distribution among the MCOs.

4.3.6.2 [Amendment #5:] Beginning in January 2021, DHHS shall reward one or more MCOs with membership auto-assignment in accordance with separate Performance-Based Auto-Assignment Program Guidance. Program features include:

~~[Base Contract:] DHHS may revise its auto-assignment methodology to reward those MCOs that demonstrate superior performance on one (1) or more key dimensions of performance as determined by DHHS. The implementation of a performance factor shall be at DHHS's discretion and would potentially precede the equitable distribution factor.~~

4.3.6.2.1 [Amendment #5:] Award(s) of additional membership to eligible high-performing MCO(s) based on performance.

4.3.6.2.2 [Amendment #8:] [Amendment #6:] [Amendment #5:] Membership awards described in separate guidance may include, but are not limited to the following preferential auto-assignment awards by distribution period for high-performing MCO(s):

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[Amendment #10:] Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)					
Distribution for Period Ending	Health Risk Assessment Completion	Encounter Data Timeliness Completeness and Quality	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Total Possible Members Awarded by Period
9/30/2023	2,000			1,000	3,000
12/31/2023	2,000		1,000		3,000
3/31/2024		1,000	1,000	1,000	3,000
6/30/2024		3,000			3,000
8/31/2024			2,000		2,000

[Amendment #8:] Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)								
Distribution Period for Quarter Ending	Health Risk Assessment Completion	Encounter Data Timeliness Completeness and Quality	30 Day Re-admissions to Inpatient Psychiatric Facility	ABD and DD Waiver Members Enrolled in MCO Care Management	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Members Discharged from the ED for a SUD Condition Who are Connected to Treatment	Total Possible Members Awarded By Quarter
3/31/2023	1,000	1,000					1,000	3,000
6/30/2023			1,000	2,000				3,000

[Amendment #6:] Performance Categories and Preferential Member Auto-Assignment Awards to High-Performing MCO(s)							
Distribution Period for Quarter Ending	Health Risk Assessment Completion	Encounter Data Timeliness, Completeness and Quality	Plan-adjusted Psychiatric Boarding	Members Enrolled in MCO Care Management	MCO Follow-up for Members Discharged from MCO Care Management	Members Discharged from the ED for a SUD Condition Who are Connected to Treatment	Total Possible Members Awarded By Quarter
12/31/2021	1,000			2,000			3,000
3/31/2022		1,000		1,000	1,000		3,000

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6/30/2022			3,000				3,000
9/30/2022				1,500	1,500		3,000
12/31/2022				1,000	1,000	1,000	3,000

4.3.6.2.2.1. [Amendment #6:] Intentionally left blank
[Amendment #5:] Health Risk Assessment Completions
 (preferential auto-assignment of 1,000 members);

4.3.6.2.2.2. [Amendment #6:] Intentionally left blank
[Amendment #5:] Encounter Data Timeliness,
Completeness and Quality (preferential auto-
 assignment of 1,000 members); and

4.3.6.2.2.3. [Amendment #6:] Intentionally left blank
[Amendment #5:] Plan-adjusted Psychiatric Boarding
 (preferential auto-assignment of 3,000 members).

4.3.6.3 [Amendment #5:] Members who meet factors described in
Sections 4.3.6.1.1 through 4.3.6.1.3 shall be excluded from MCO
auto-assignment awards under the program. DHHS reserves the right
to change the auto-assignment process at its discretion.

4.3.6.3.4 [Amendment #5:] 4-3-6-3 DHHS reserves the right to change the
 auto-assignment process at its discretion.

4.3.7 Disenrollment

4.3.7.1 Member Disenrollment Request

4.3.7.1.1 A Member may request disenrollment "with cause" to
 DHHS at any time during the coverage year when:

4.3.7.1.1.1. The Member moves out of state;

4.3.7.1.1.2. The Member needs related services to
 be performed at the same time; not all related services
 are available within the network; and receiving the
 services separately would subject the Member to
 unnecessary risk;

4.3.7.1.1.3. Other reasons, including but not limited
 to poor quality of care, lack of access to services
 covered under the Agreement, violation of rights, or lack
 of access to Providers experienced in dealing with the
 Member's health care needs. [42 CFR 438.56(d)(2)]; or

4.3.7.1.1.4. The MCO does not cover the service the
 Member seeks because of moral or religious objections.
 [42 CFR 438.56(d)(2)(i) - (ii)]

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4.3.7.1.1.5. [Amendment #5:] For Member disenrollment requests "with cause" as described in Sections 4.3.7.1.1.2 through 4.3.7.1.1.4, the Member shall first seek redress through the MCO's grievance system.

4.3.7.1.2 A Member may request disenrollment "without cause" at the following times:

4.3.7.1.2.1. During the ninety (90) calendar days following the date of the Member's initial enrollment into the MCO or the date of the DHHS Member notice of the initial auto-assignment/enrollment, whichever is later;

4.3.7.1.2.2. For Members who have an established relationship with a PCP that is only in the network of a non-assigned MCO, the Member can request disenrollment during the first twelve (12) months of enrollment at any time and enroll in the non-assigned MCO;

4.3.7.1.2.3. Once every twelve (12) months;

4.3.7.1.2.4. During enrollment related to renegotiation and re-procurement;

4.3.7.1.2.5. For sixty (60) calendar days following an automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual enrollment/disenrollment opportunity (this provision applies to re-determinations only and does not apply when a Member is completing a new application for Medicaid eligibility); and

4.3.7.1.2.6. When DHHS imposes a sanction on the MCO. [42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i)-(iii)]

4.3.7.1.3 The MCO shall provide Members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period. The notice shall include an explanation of all of the Member's disenrollment rights as specified in this Agreement. [42 CFR 438.56(f)]

4.3.7.1.4 If a Member is requesting disenrollment, the Member (or his or her authorized representative) shall submit an oral or written request to DHHS. [42 CFR 438.56(d)(1)]

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4.3.7.1.5 The MCO shall furnish all relevant information to DHHS for its determination regarding disenrollment, within three (3) business days after receipt of DHHS's request for information.

4.3.7.1.6 [Amendment #6:] Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the Member files the request.

4.3.7.1.7 If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e); 42 CFR 438.56(d)(3); 42 CFR 438.3(q); 42 CFR 438.56(c)]

4.3.7.2 MCO Disenrollment Request

4.3.7.2.1 The MCO shall submit involuntary disenrollment requests to DHHS with proper documentation for the following reasons:

4.3.7.2.1.1. Member has established out of state residence;

4.3.7.2.1.2. Member death;

4.3.7.2.1.3. Determination that the Member is ineligible for enrollment due to being deemed part of an excluded population;

4.3.7.2.1.4. Fraudulent use of the Member identification card; or

4.3.7.2.1.5. In the event of a Member's threatening or abusive behavior that jeopardizes the health or safety of Members, staff, or Providers. [42 CFR 438.56(b)(1); 42 CFR 438.56(b)(3)]

4.3.7.2.2 The MCO shall not request disenrollment because of:

4.3.7.2.2.1. An adverse change in the Member's health status;

4.3.7.2.2.2. The Member's utilization of medical services;

4.3.7.2.2.3. The Member's diminished mental capacity;

4.3.7.2.2.4. The Member's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in

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the MCO seriously impairs the entity's ability to furnish services to either the particular Member or other Members); or

4.3.7.2.2.5. The Member's misuse of substances, prescribed or illicit, and any legal consequences resulting from substance misuse. [Section 1903(m)(2)(A)(v) of the Social Security Act; 42 CFR 438.56(b)(2)]

4.3.7.2.3 If an MCO is requesting disenrollment of a Member, the MCO shall:

4.3.7.2.3.1. Specify the reasons for the requested disenrollment of the Member; and

4.3.7.2.3.2. Submit a request for involuntary disenrollment to DHHS along with documentation and justification, for review.

4.3.7.2.4 [Amendment #6:] Regardless of the reason for disenrollment, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the MCO files the request.

4.3.7.2.5 If DHHS fails to make a disenrollment determination within this specified timeframe, the disenrollment is considered approved. [42 CFR 438.56(e)]

4.3.8 Relationship with Enrollment Services

4.3.8.1 The MCO shall furnish information to DHHS or its designee to ensure that, before enrolling, the recipient receives the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

4.4 Member Services

4.4.1 Member Information

4.4.1.1 [Amendment #3:] The MCO shall perform the Member Services responsibilities contained in this Agreement for all Members, including Granite Advantage Members. ~~in accordance with DHHS guidance and the responsibilities described in Section 4.3.2.1 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members).~~

4.4.1.2 Primary Care Provider Information

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4.4.1.2.1 The MCO shall send a letter to a Member upon initial enrollment, and anytime the Member requests a new PCP, confirming the Member's PCP and providing the PCP's name, address, and telephone number.

4.4.1.3 Member Identification Card

4.4.1.3.1 The MCO shall issue an identification card to all New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment.

4.4.1.3.2 The identification card shall include, but is not limited to, the following information and any additional information shall be approved by DHHS prior to use on the identification card:

4.4.1.3.2.1. The Member's name;

4.4.1.3.2.2. The Member's DOB;

4.4.1.3.2.3. The Member's Medicaid identification number assigned by DHHS at the time of eligibility determination;

4.4.1.3.2.4. The name of the MCO;

4.4.1.3.2.5. The twenty-four (24) hours a day, seven (7) days a week toll-free Member Services telephone/hotline number operated by the MCO; and

4.4.1.3.2.6. How to file an appeal or grievance.

4.4.1.3.3 The MCO shall reissue a Member identification card if:

4.4.1.3.3.1. A Member reports a lost card;

4.4.1.3.3.2. A Member has a name change; or

4.4.1.3.3.3. Any other reason that results in a change to the information disclosed on the identification card.

4.4.1.4 Member Handbook

4.4.1.4.1 The MCO shall publish and provide Member information in the form of a Member Handbook at the time of Member enrollment in the plan and, at a minimum, on an annual basis thereafter. The Member Handbook shall be based upon the model Member Handbook developed by DHHS. [42 CFR 438.10(g)(1), 45 CFR 147.200(a); 42 CFR 438.10(c)(4)(ii)]

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4.4.1.4.2 The MCO shall inform all Members by mail of their right to receive free of charge a written copy of the Member Handbook. The MCO shall provide program content that is coordinated and collaborative with other DHHS initiatives. The MCO shall submit the Member Handbook to DHHS for review at the time it is developed as part of Readiness Review and after any substantive revisions at least thirty (30) calendar days prior to the effective date of such change.

4.4.1.4.3 The Member Handbook shall be in easily understood language, and include, but not be limited to, the following information:

4.4.1.4.3.1. General Information:

4.4.1.4.3.1.1 A table of contents;

4.4.1.4.3.1.2 How to access Auxiliary Aids and services, including additional information in alternative formats or languages [42 CFR 438.10(g)(2)(xiii) - (xvi), 42 CFR 438.10(d)(5)(i) - (iii)];

4.4.1.4.3.1.3 [Amendment #6:] DHHS developed definitions, including but not limited to: appeal, Copayment, DME, Emergency Medical Condition, emergency medical transportation, emergency room care, Emergency Services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, ~~hospital outpatient care~~, Medically Necessary, network, Non-Participating Provider, Participating Provider, PCP, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, Provider, rehabilitation services and devices, skilled nursing care, specialist; and urgent care [42 CFR 438.10(c)(4)(i)];

4.4.1.4.3.1.4 The necessity definitions used in determining whether services will be covered;

4.4.1.4.3.1.5 A reminder to report to DHHS any change of address, as Members shall be liable for premium payments paid during period of ineligibility;

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4.4.1.4.3.1.6 Information and guidance as to how the Member can effectively use the managed care program [42 CFR 438.10(g)(2)];

4.4.1.4.3.1.7 Appointment procedures;

4.4.1.4.3.1.8 How to contact Service Link Aging and Disability Resource Center and the DHHS Medicaid Service Center that can provide all Members and potential Members choice counseling and information on managed care;

4.4.1.4.3.1.9 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including the MCO's toll-free telephone line and website, the toll-free telephone number for Member Services, the toll-free telephone number for Medical Management, and the toll-free telephone number for any other unit providing services directly to Members [42 CFR 438.10(g)(2)(xiii) - (xvi)];

4.4.1.4.3.1.10 How to access the NH DHHS Office of the Ombudsman and the NH Office of the Long Term Care Ombudsman;

4.4.1.4.3.1.11 The policies and procedures for disenrollment;

4.4.1.4.3.1.12 A description of the transition of care policies for potential Members and Members [42 CFR 438.62(b)(3)];

4.4.1.4.3.1.13 Cost-sharing requirements [42 CFR 438.10(g)(2)(viii)];

4.4.1.4.3.1.14 A description of utilization review policies and procedures used by the MCO;

4.4.1.4.3.1.15 A statement that additional information, including information on the structure and operation of the MCO plan and Physician Incentive Plans, shall be made available upon request [42 CFR 438.10(f)(3), 42 CFR 438.3(i)];

4.4.1.4.3.1.16 Information on how to report suspected fraud or abuse [42 CFR 438.10(g)(2)(xiii) - (xvi)];

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4.4.1.4.3.1.17 Information about the role of the PCP and information about choosing and changing a PCP [42 CFR 438.10(g)(2)(x)];

4.4.1.4.3.1.18 Non-Participating Providers and cost-sharing on any benefits carved out and provided by DHHS [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.1.19 How to exercise Advance Directives [42 CFR 438.10(g)(2)(xii), 42 CFR 438.3(j)];

4.4.1.4.3.1.20 Advance Directive policies which include a description of current State law. [42 CFR 438.3(j)(3)];

4.4.1.4.3.1.21 Information on the parity compliance process, including the appropriate contact information, as required by Section 4.11.4. (Parity);

4.4.1.4.3.1.22 [Amendment #3:] Intentionally left blank. Any information pertaining to Granite Advantage Members as required by Section 4.3.2.4 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members); and

4.4.1.4.3.1.23 Any restrictions on the Member's freedom of choice among Participating Providers [42 CFR 438.10(g)(2)(vi) - (vii)].

4.4.1.4.3.2. Benefits:

4.4.1.4.3.2.1 How and where to access any benefits provided, including Maternity services, Family Planning Services and NEMT services [42 CFR 438.10(g)(2)(i)-(ii), (vi - vii)].

4.4.1.4.3.2.2 Detailed information regarding the amount, duration, and scope of all available benefits so that Members understand the benefits to which they are entitled [42 CFR 438.10(g)(2)(iii) - (iv)];

4.4.1.4.3.2.3 How to access EPSDT services and component services if Members under age twenty-one (21) entitled to the EPSDT benefit are enrolled in the MCO;

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4.4.1.4.3.2.4 How and where to access EPSDT benefits delivered outside the MCO, if any [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.2.5 How transportation is provided for any benefits carved out of this Agreement and provided by DHHS [42 CFR 438.10(g)(2)(i) - (ii)];

4.4.1.4.3.2.6 Information explaining that, in the case of a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO shall inform Members that the service is not covered and how Members can obtain information from DHHS about how to access those services [42 CFR 438.10(g)(2)(ii)(A) - (B), 42 CFR 438.102(b)(2)];

4.4.1.4.3.2.7 A description of pharmacy policies and pharmacy programs; and

4.4.1.4.3.2.8 How emergency care is provided, including:

4.4.1.4.3.2.8.1.1 The extent to which, and how, after hours and emergency coverage are provided;

4.4.1.4.3.2.8.1.2 What constitutes an Emergency Service and an Emergency Medical Condition;

4.4.1.4.3.2.8.1.3 The fact that Prior Authorization is not required for Emergency Services; and

4.4.1.4.3.2.8.1.4 The Member's right to use a hospital or any other setting for emergency care [42 CFR 438.10(g)(2)(v)].

4.4.1.4.3.3. Service Limitations:

4.4.1.4.3.3.1 An explanation of any service limitations or exclusions from coverage;

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4.4.1.4.3.3.2 An explanation that the MCO cannot require a Member to receive prior approval prior to choosing a family planning Provider [42 CFR 438.10(g)(2)(vii)];

4.4.1.4.3.3.3 A description of all pre-certification, Prior Authorization criteria, or other requirements for treatments and services;

4.4.1.4.3.3.4 Information regarding Prior Authorization in the event the Member chooses to transfer to another MCO and the Member's right to continue to utilize a Provider specified in a Prior Authorization for a period of time regardless of whether the Provider is participating in the MCO network;

4.4.1.4.3.3.5 The policy on referrals for specialty care and for other Covered Services not furnished by the Member's PCP [42 CFR 438.10(g)(2)(iii) - (iv)];

4.4.1.4.3.3.6 Information on how to obtain services when the Member is out-of-state and for after-hours coverage [42 CFR 438.10(g)(2)(v)]; and

4.4.1.4.3.3.7 A notice stating that the MCO shall be liable only for those services authorized by or required of the MCO.

4.4.1.4.3.4. Rights and Responsibilities:

4.4.1.4.3.4.1 Member rights and protections, outlined in Section 4.4.3 (Member Rights), including the Member's right to obtain available and accessible health care services covered under the MCO. [42 CFR 438.100(b)(2)(i) - (vi), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(b)(3)].

4.4.1.4.3.5. Grievances, Appeals, and Fair Hearings Procedures and Timeframes:

4.4.1.4.3.5.1 The right to file grievances and appeals;

4.4.1.4.3.5.2 The requirements and timeframes for filing grievances or appeals;

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4.4.1.4.3.5.3 The availability of assistance in the filing process for grievances and appeals;

4.4.1.4.3.5.4 The right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and

4.4.1.4.3.5.5 The right to have benefits continue pending the appeal or request for State fair hearing if the decision involves the reduction or termination of benefits, however, if the Member receives an adverse decision then the Member may be required to pay for the cost of service(s) furnished while the appeal or State fair hearing is pending. [42 CFR 438.10(g)(2)(xi)(A)-(E)]

4.4.1.4.4 Member Handbook Dissemination

4.4.1.4.4.1. The MCO shall mail the Member Handbook to new Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment. [42 CFR 438.10(g)(3)(i) - (iv)]

4.4.1.4.4.2. The MCO shall advise the Member in paper or electronic form that the Member Handbook information is available on the internet, and include the applicable internet address, provided that Members with disabilities who cannot access this information online are provided Auxiliary Aids and services upon request at no cost. [42 CFR 438.10(d)(3)] Alternatively, the MCO may provide the information by any other method that can reasonably be expected to result in the Member receiving that information. The MCO shall provide the Member Handbook information by email after obtaining the Member's agreement to receive the information electronically. [42 CFR 438.10(g)(3)(i) - (iv)]

4.4.1.4.4.3. The MCO shall notify all Members, at least once a year, of their right to obtain a Member Handbook and shall maintain consistent and up-to-date information on the MCO's website. [42 CFR 438.10(g)(3)(i) - (iv)] The Member information appearing on the website (also available in paper form) shall include the following, at a minimum:

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4.4.1.4.4.3.1 Information contained in the Member Handbook;

4.4.1.4.4.3.2 Information on how to file grievances and appeals;

4.4.1.4.4.3.3 Information on the MCO's Provider network for all Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers):

- (1) Names and any group affiliations;
- (2) Street addresses;
- (3) Office hours;
- (4) Telephone numbers;
- (5) [Amendment #7:] Website (whenever web presence exists) (if applicable);
- (6) Specialty (if any),
- (7) Description of accommodations offered for people with disabilities;
- (8) [Amendment #10:] The cultural and linguistic capabilities of Participating Providers, including languages (including American Sign Language (ASL)) offered by the Provider or a skilled medical interpreter at the Provider's office, and whether the Provider has completed cultural competence training;
- (9) Gender of the Provider;
- (10) Identification of Providers that are not accepting new Members; and
- (11) Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(g)(2)(vi) - (vii)]

4.4.1.4.4.4. The MCO shall produce a revised Member Handbook, or an insert, informing Members of changes to Covered Services, upon DHHS notification of any change in Covered Services, and at least thirty

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(30) calendar days prior to the effective date of such change. This includes notification of any policy to discontinue coverage of a counseling or referral service based on moral or religious objections and how the Member can access those services. [42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4)]

4.4.1.4.4.5. [Amendment #9:] The MCO shall use Member notices, as applicable, in accordance with the model notices developed by DHHS. [42 CFR 438.10(c)(4)(ii)] For any change that affects Member rights, filing requirements, time frames for grievances, appeals, and State fair hearings, availability of assistance in submitting grievances and appeals, and toll-free numbers of the MCO grievance system resources, the MCO shall give each Member written notice of the change at least thirty (30) calendar days before the intended effective date of the change. ~~The MCO shall also notify all Members of their disenrollment rights, at a minimum, annually.~~ The MCO shall utilize notices that describe transition of care policies for Members and potential Members. [42 CFR 438.62(b)(3)]

4.4.1.5 Provider Directory

4.4.1.5.1 The MCO shall publish a Provider Directory that shall be reviewed by DHHS prior to initial publication and distribution. The MCO shall submit the draft Provider Directory and all substantive changes to DHHS for review.

4.4.1.5.2 The following information shall be in the MCO's Provider Directory for all Participating Provider types covered under this Agreement (e.g., PCPs, specialists, family planning Providers, pharmacies, FQHCs, RHCs, hospitals, and mental health and Substance Use Disorder Providers):

- 4.4.1.5.2.1. Names and any group affiliations;
- 4.4.1.5.2.2. Street addresses;
- 4.4.1.5.2.3. Office hours;
- 4.4.1.5.2.4. Telephone numbers;
- 4.4.1.5.2.5. [Amendment #7:] Website (whenever web presence exists) (if applicable);
- 4.4.1.5.2.6. Specialty (if any),

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- 4.4.1.5.2.7. Gender;
- 4.4.1.5.2.8. Description of accommodations offered for people with disabilities;
- 4.4.1.5.2.9. [Amendment #8:] The cultural and linguistic capabilities of Participating Providers, including languages (including ASL) offered by the Participating Provider or a skilled medical interpreter at the Provider's office, ~~and whether the Participating Provider has completed cultural competence training;~~
- 4.4.1.5.2.10. Hospital affiliations (if applicable);
- 4.4.1.5.2.11. Board certification (if applicable);
- 4.4.1.5.2.12. Identification of Participating Providers that are not accepting new patients; and
- 4.4.1.5.2.13. Any restrictions on the Member's freedom of choice among Participating Providers. [42 CFR 438.10(h)(1)(i) - (viii); 42 CFR 438.10(h)(2)]

4.4.1.5.3 The MCO shall send a letter to New Members within ten (10) calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven (7) calendar days after the effective date of enrollment directing the Member to the Provider Directory on the MCO's website and informing the Member of the right to a printed version of the Provider Directory upon request.

4.4.1.5.4 The MCO shall disseminate Practice Guidelines to Members and potential Members upon request as described in Section 4.8.2. (Practice Guidelines and Standards). [42 CFR 438.236(c)]

4.4.1.5.5 The MCO shall notify all Members, at least once a year, of their right to obtain a paper copy of the Provider Directory and shall maintain consistent and up-to-date information on the MCO's website in a machine readable file and format as specified by CMS.

4.4.1.5.6 [Amendment #8:] The MCO shall update the paper copy of the Provider Directory at least monthly if the MCO does not have a mobile-enabled electronic directory, or quarterly, if the MCO has a mobile-enabled, electronic provider directory; and shall update an electronic directory no later than thirty (30) calendar days after the MCO receives updated *provider* information. [42 CFR 438.10(h)(3-4)].

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4.4.1.5.7 The MCO shall post on its website a searchable list of all Participating Providers. At a minimum, this list shall be searchable by Provider name, specialty, location, and whether the Provider is accepting new Members.

4.4.1.5.8 The MCO shall update the Provider Directory on its website within seven (7) calendar days of any changes. The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory.

4.4.1.5.9 Thirty (30) calendar days after the effective date of this Agreement or ninety (90) calendar days prior to the Program Start Date, whichever is later, the MCO shall develop and submit the draft website Provider Directory template to DHHS for review; thirty (30) calendar days prior to Program Start Date the MCO shall submit the final website Provider Directory.

4.4.1.5.10 Upon the termination of a Participating Provider, the MCO shall make good faith efforts within fifteen (15) calendar days of the notice of termination to notify Members who received their primary care from, or was seen on a regular basis by, the terminated Provider. [42 CFR 438.10(f)(1)]

4.4.2 Language and Format of Member Information

4.4.2.1 The MCO shall have in place mechanisms to help potential Members and Members understand the requirements and benefits of the MCO. [42 CFR 438.10(c)(7)]

4.4.2.2 The MCO shall use the DHHS developed definitions consistently in any form of Member communication. The MCO shall develop Member materials utilizing readability principles appropriate for the population served.

4.4.2.3 The MCO shall provide all enrollment notices, information materials, and instructional materials relating to Members and potential Members in a manner and format that may be easily understood and readily accessible in a font size no smaller than twelve (12) point. [42 CFR 438.10(c)(1), 42 CFR 438.10(d)(6)(ii) - (iv)]

4.4.2.4 The MCO's written materials shall be developed in compliance with all applicable communication access requirements at the request of the Member or prospective Member at no cost.

4.4.2.5 Information shall be communicated in an easily understood language and format, including alternative formats and in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities or LEP.

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4.4.2.6 The MCO shall inform Members that information is available in alternative formats and how to access those formats. [42 CFR 438.10(d)(3), 42 CFR 438.10(d)(6)(i) - (iv)]

4.4.2.7 The MCO shall make all written Member information available in English, Spanish, and any other state-defined prevalent non-English languages of MCM Members. [42 CFR 438.10(d)(1)]

4.4.2.8 [Amendment #5:] All written Member information critical to obtaining services for potential enrollees shall include at the bottom, taglines printed in a conspicuously visible font size in large print, and in the non-English languages prevalent among MCM Members, to explaining the availability of written translation or oral interpretation, to understand the information provided and include the toll-free and teletypewriter (TTY)/TDD telephone number of the MCO's Member Services Center. [42 CFR 438.10(d)(3)]

4.4.2.9 [Amendment #5:] The large print tagline must be printed in a conspicuously visible font size, and shall include information on how to request Auxiliary Aids and services, including materials in alternative formats. Upon request, the MCO shall provide all written Member and potential enrollee critical to obtaining services information in large print with a font size no smaller than eighteen (18) point. [42 CFR 438.10(d)(2-3), 42 CFR 438.10(d)(6)(ii) - (iv)]

4.4.2.10 Written Member information shall include at a minimum:

- 4.4.2.10.1 Provider Directories;
- 4.4.2.10.2 Member Handbooks;
- 4.4.2.10.3 Appeal and grievance notices; and
- 4.4.2.10.4 Denial and termination notices.

4.4.2.11 The MCO shall also make oral interpretation services available free of charge to Members and potential Members for MCO Covered Services. This applies to all non-English languages, not just those that DHHS identifies as languages of other major population groups. Members shall not to be charged for interpretation services. [42 CFR 438.10(d)(4)]

4.4.2.12 The MCO shall notify Members that oral interpretation is available for any language and written information is available in languages prevalent among MCM Members; the MCO shall notify Members of how to access those services. [42 CFR 438.10(d)(4), 42 CFR 438.10(d)(5)(i) - (iii)]

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4.4.2.13 The MCO shall provide Auxiliary Aids such as TTY/TDD and ASL interpreters free of charge to Members or potential Members who require these services. [42 CFR 438.10(d)(4)] The MCO shall take into consideration the special needs of Members or potential Members with disabilities or LEP. [42 CFR 438.10(d)(5)(i) - (iii)]

4.4.3 Member Rights

4.4.3.1 The MCO shall have written policies which shall be included in the Member Handbook and posted on the MCO website regarding Member rights, such that each Member is guaranteed the right to:

4.4.3.1.1 Receive information on the MCM program and the MCO to which the Member is enrolled;

4.4.3.1.2 Be treated with respect and with due consideration for his or her dignity and privacy and the confidentiality of his or her PHI and PI as safeguarded by State rules and State and federal laws;

4.4.3.1.3 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

4.4.3.1.4 Participate in decisions regarding his/her health care, including the right to refuse treatment;

4.4.3.1.5 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

4.4.3.1.6 Request and receive a copy of his/her medical records free of charge, and to request that they be amended or corrected;

4.4.3.1.7 Request and receive any MCO's written Physician Incentive Plans;

4.4.3.1.8 Obtain benefits, including Family Planning Services and supplies, from Non-Participating Providers;

4.4.3.1.9 Request and receive a Second Opinion; and

4.4.3.1.10 Exercise these rights without the MCO or its Participating Providers treating the Member adversely. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(i)-(vi)]; 42 CFR 438.100(c); 42 CFR 438.10(f)(3); 42 CFR 438.10(g)(2)(vi) - (vii); 42 CFR 438.10(g)(2)(ix); 42 CFR 438.3(i)]

4.4.4 Member Communication Supports

4.4.4.1 The MCO shall embrace and further the concept of "every door for Members is the right door" to eliminate barriers and create a

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more flexible and responsive approach to person-centered service delivery. The MCO shall provide twenty-four (24) hours a day, seven (7) days a week supports such as PCP, behavioral health and specialist referrals, health coaching, assistance with social determinants of health, access to a nurse advice line, and a Member portal.

4.4.4.2 During the Readiness Review period, the MCO shall provide a blueprint of its Member portal for review by DHHS.

4.4.4.3 Member Call Center

4.4.4.3.1 [Amendment #5:] The MCO shall operate a toll-free NH specific call center Monday through Friday. The MCO shall submit the holiday calendar to DHHS for review and approval ninety (90) calendar days prior to the end of each calendar year.

4.4.4.3.2 The MCO shall ensure that the Member Call Center integrates support for physical and Behavioral Health Services including meeting the requirement that the MCO have a call line that is in compliance with requirements set forth in Section 4.11.1.19 (Member Service Line), works efficiently to resolve issues, and is adequately staffed with qualified personnel who are trained to accurately respond to Members. At a minimum, the Member Call Center shall be operational:

4.4.4.3.2.1. Two (2) days per week: eight (8:00) am Eastern Standard Time (EST) to five (5:00) pm EST;

4.4.4.3.2.2. Three (3) days per week: eight (8:00) am EST to eight (8:00) pm EST; and

4.4.4.3.2.3. During major program transitions, additional hours and capacity shall be accommodated by the MCO.

4.4.4.3.3 The Member Call Center shall meet the following, minimum standards, which DHHS reserves the right to modify at any time:

4.4.4.3.3.1. Call Abandonment Rate: Fewer than five percent (5%) of calls shall be abandoned;

4.4.4.3.3.2. [Amendment #5:] Average Speed of Answer: Eighty-five percent (85%) ~~Ninety percent (90%)~~ of calls shall be answered with live voice within thirty (30) seconds; and

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4.4.4.3.3. Voicemail or answering service messages shall be responded to no later than the next business day.

4.4.4.3.4 [Amendment #5:] The MCO shall coordinate its Member Call Center with the DHHS Customer Service Center, the Member Service Line and all community-based and statewide crisis lines to include, at a minimum, the development of a warm transfer protocol for Members.

4.4.4.4 Welcome Call

4.4.4.4.1 The MCO shall make a welcome call to each New Member within thirty (30) calendar days of the Member's enrollment in the MCO.

4.4.4.4.2 The welcome call shall, at a minimum:

4.4.4.4.2.1. Assist the Member in selecting a PCP or confirm selection of a PCP;

4.4.4.4.2.2. Arrange for a wellness visit with the Member's PCP (either previously identified or selected by the Member from a list of available PCPs), which shall include:

4.4.4.4.2.2.1 Assessments of both physical and behavioral health,

4.4.4.4.2.2.2 Screening for depression, mood, suicidality, and Substance Use Disorder, and

4.4.4.4.2.2.3 Development of a health, wellness and care plan;

4.4.4.4.2.3. Include a Health Risk Assessment Screening as required in Section 4.10.2.2, or schedule the Health Risk Assessment to be conducted within the time limits identified in this Agreement;

4.4.4.4.2.4. Screen for special needs, physical and behavioral health, and services of the Member;

4.4.4.4.2.5. Answer any other Member questions about the MCO;

4.4.4.4.2.6. Ensure Members can access information in their preferred language; and

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4.4.4.4.2.7. Remind Members to report to DHHS any change of address, as Members shall be liable for premium payments paid during period of ineligibility.

4.4.4.4.3 Regardless of the completion of the welcome call, the MCO shall complete Health Risk Assessment Screenings as required in 4.10.2.2

4.4.4.5 Member Hotline

4.4.4.5.1 The MCO shall establish a toll-free Member Service automated hotline that operates outside of the Member Call Center standard hours, Monday through Friday, and at all hours on weekends and holidays.

4.4.4.5.2 The automated system shall provide callers with operating instructions on what to do and who to call in case of an emergency, and shall also include, at a minimum, a voice mailbox for Members to leave messages.

4.4.4.5.3 The MCO shall ensure that the voice mailbox has adequate capacity to receive all messages. Return voicemail calls shall be made no later than the next business day.

4.4.4.5.4 The MCO may substitute a live answering service in place of an automated system.

4.4.4.6 Program Website

4.4.4.6.1 The MCO shall develop and maintain, consistent with DHHS standards and other applicable State and federal laws, a website to provide general information about the MCO's program, its Participating Provider network, its formulary, Prior Authorization requirements, the Member Handbook, its services for Members, and its Grievance and Appeal Processes.

4.4.4.6.2 The MCO shall ensure that any PHI, PI or other Confidential Information solicited shall not be maintained, stored or captured on the website and shall not be further disclosed except as provided by this Agreement.

4.4.4.6.3 The solicitation or disclosure of any PHI, PI or other Confidential Information shall be subject to the requirements in Exhibit I, Exhibit K Exhibit N (Liquidated Damages Matrix) and all applicable State and federal laws, rules, and regulations.

4.4.4.6.4 Unless approved by DHHS and clear notice is provided to users of the website, the MCO shall not track, disclose or use site visitation for its website analytics or marketing.

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4.4.4.6.5 If the MCO chooses to provide required information electronically to Members, it shall:

4.4.4.6.5.1. Be in a format and location that is prominent and readily accessible;

4.4.4.6.5.2. Be provided in an electronic form which can be electronically retained and printed;

4.4.4.6.5.3. Be consistent with content and language requirements;

4.4.4.6.5.4. Notify the Member that the information is available in paper form without charge upon request; and

4.4.4.6.5.5. Provide, upon request, information in paper form within five (5) business days. [42 CFR 438.10(c)(6)(i) - (v)]

4.4.4.6.6 The MCO program content included on the website shall be:

4.4.4.6.6.1. Written in English, Spanish, and any other of the commonly encountered languages of Members;

4.4.4.6.6.2. Culturally appropriate;

4.4.4.6.6.3. Appropriate to the reading literacy of the population served; and

4.4.4.6.6.4. Geared to the health needs of the enrolled MCO program population.

4.4.4.6.7 The MCO's website shall be compliant with the federal DOJ "Accessibility of State and Local Government Websites to People with Disabilities."

4.4.5 Marketing

4.4.5.1 The MCO shall not, directly or indirectly, conduct door-to-door, telephonic, or other Cold Call Marketing to potential Members. The MCO shall submit all MCO Marketing material to DHHS for approval before distribution.

4.4.5.2 DHHS shall identify any required changes to the Marketing Materials within thirty (30) calendar days. If DHHS has not responded to a request for review by the thirtieth calendar day, the MCO may proceed to use the submitted materials. [42 CFR 438.104(b)(1)(i) - (ii), 42 CFR 438.104(b)(1)(iv) - (v)]

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4.4.5.3 The MCO shall comply with federal requirements for provision of information that ensures the potential Member is provided with accurate oral and written information sufficient to make an informed decision on whether or not to enroll.

4.4.5.4 The MCO Marketing Materials shall not contain false or materially misleading information. The MCO shall not offer other insurance products as inducement to enroll.

4.4.5.5 The MCO shall ensure that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or DHHS. The MCO's Marketing Materials shall not contain any written or oral assertions or statements that:

4.4.5.5.1 The recipient shall enroll in the MCO in order to obtain benefits or in order not to lose benefits; or

4.4.5.5.2 The MCO is endorsed by CMS, the State or federal government, or a similar entity. [42 CFR 438.104(b)(2)(i) - (ii)]

4.4.5.6 The MCO shall distribute Marketing Materials to the entire State. The MCO's Marketing Materials shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. The MCO shall not release and make public statements or press releases concerning the program without the prior consent of DHHS. [42 CFR 438.104(b)(1)(i) - (ii), 42 CFR 438.104(b)(1)(iv) - (v)]

4.4.6 Member Engagement Strategy

4.4.6.1 The MCO shall develop and facilitate an active Member Advisory Board that is composed of Members who represent its Member population.

4.4.6.2 Member Advisory Board

4.4.6.2.1 Representation on the Member Advisory Board shall draw from and be reflective of the MCO membership to ensure accurate and timely feedback on the MCM program.

4.4.6.2.2 The Member Advisory Board shall meet at least four (4) times per year.

4.4.6.2.3 The Member Advisory Board shall meet in-person or through interactive technology, including but not limited to a conference call or webinar and provide Member perspective(s) to influence the MCO's QAPI program changes (as further described in Section 4.12.3 (Quality Assessment and Performance Improvement Program)).

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4.4.6.2.4 All costs related to the Member Advisory Board shall be the responsibility of the MCO.

4.4.6.3 In-Person Regional Member Meetings

4.4.6.3.1 The MCO shall hold in-person regional Member meetings for two-way communication where Members can provide input and ask questions, and the MCO can ask questions and obtain feedback from Members.

4.4.6.3.2 Regional meetings shall be held at least twice each Agreement year in demographically different locations in NH. The MCO shall make efforts to provide video conferencing opportunities for Members to attend the regional meetings. If video conferencing is unavailable, the MCO shall use alternate technologies as available for all meetings.

4.4.6.3.3 [Amendment #6:] Intentionally left blank ~~The MCO shall report on the activities of these meetings including a summary of meeting dates, attendees, topics discussed and actions taken in response to Member contributions to DHHS in the MCM Comprehensive Annual Report, in accordance with Exhibit O.~~

4.4.6.3.4 [Amendment #5:] For the period January 1, 2021 through June 30, 2021, the MCO may utilize remote technologies for regional Member meetings.

4.4.6.3.4.1. [Amendment #6:] Beginning July 1, 2021, the MCO shall accommodate in-person and remote technologies for regional Member meetings.

4.4.7 Cultural and Accessibility Considerations

4.4.7.1 The MCO shall participate in DHHS's efforts to promote the delivery of services in a culturally and linguistically competent manner to all Members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [42 CFR 438.206(c)(2)]

4.4.7.2 The MCO shall ensure that Participating Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or behavioral disabilities. [42 CFR 438.206(c)(3)]

4.4.7.3 Cultural Competency Plan

4.4.7.3.1 In accordance with 42 CFR 438.206, the MCO shall have a comprehensive written Cultural Competency Plan describing how it will ensure that services are provided in a culturally and

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linguistically competent manner to all Members, including those with LEP, using qualified staff, interpreters, and translators in accordance with Exhibit O.

4.4.7.3.2 The Cultural Competency Plan shall describe how the Participating Providers, and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the each Member and protects and preserves a Member's dignity.

4.4.7.3.3 The MCO shall work with the DHHS Office of Health Equity to address cultural and linguistic considerations.

4.4.7.4 Communication Access

4.4.7.4.1 The MCO shall develop effective methods of communicating and working with its Members who do not speak English as a first language, who have physical conditions that impair their ability to speak clearly in order to be easily understood, as well as Members who have low-vision or hearing loss, and accommodating Members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities.

4.4.7.4.2 The MCO shall develop effective and appropriate methods for identifying, flagging in electronic systems, and tracking Members' needs for communication assistance for health encounters including preferred spoken language for all encounters, need for interpreter, and preferred language for written information.

4.4.7.4.3 The MCO shall adhere to certain quality standards in delivering language assistance services, including using only Qualified Bilingual/Multilingual Staff, Qualified Interpreters for a Member with a Disability, Qualified Interpreters for a Member with LEP, and Qualified Translators as defined in Section 2.1.104 through Section 2.1.107 (Definitions).

4.4.7.4.4 The MCO shall ensure the competence of employees providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. The MCO shall not:

4.4.7.4.4.1. Require a Member with LEP to provide his or her own interpreter;

4.4.7.4.4.2. Rely on an adult accompanying a Member with LEP to interpret or facilitate communication, except:

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4.4.7.4.4.2.1 , In an emergency involving an imminent threat to the safety or welfare of the Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available, or

4.4.7.4.4.2.2 Where the Member with LEP specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;

4.4.7.4.4.3. Rely on a minor to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of a Member or the public where there is no Qualified Interpreter for the Member with LEP immediately available; or

4.4.7.4.4.4. Rely on staff other than Qualified Bilingual/Multilingual Staff to communicate directly with Members with LEP. [45 CFR 92.201(e)]

4.4.7.4.5 The MCO shall ensure interpreter services are available to any Member who requests them, regardless of the prevalence of the Member's language within the overall program for all health plan and MCO services, exclusive of inpatient services.

4.4.7.4.6 The MCO shall recognize that no one interpreter service (such as over-the-phone interpretation) will be appropriate (i.e. will provide meaningful access) for all Members in all situations. The most appropriate service to use (in-person versus remote interpretation) will vary from situation to situation and shall be based upon the unique needs and circumstances of each Member.

4.4.7.4.7 Accordingly, the MCO shall provide the most appropriate interpretation service possible under the circumstances. In all cases, the MCO shall provide in-person interpreter services when deemed clinically necessary by the Provider of the encounter service.

4.4.7.4.8 The MCO shall not use low-quality video remote interpreting services. In instances where the Qualified Interpreters are being provided through video remote interpreting services, the MCO's health programs and activities shall provide:

4.4.7.4.8.1. Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-

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quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;

4.4.7.4.8.2. A sharply delineated image that is large enough to display the interpreter's face and the participating Member's face regardless of the Member's body position;

4.4.7.4.8.3. A clear, audible transmission of voices; and

4.4.7.4.8.4. Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting. [45 CFR 92.201(f)]

4.4.7.4.9 The MCO shall bear the cost of interpretive services and communication access, including ASL interpreters and translation into Braille materials as needed for Members with hearing loss and who are low-vision or visually impaired.

4.4.7.4.10 The MCO shall communicate in ways that can be understood by Members who are not literate in English or their native language. Accommodations may include the use of audio-visual presentations or other formats that can effectively convey information and its importance to the Member's health and health care.

4.4.7.4.11 If the Member declines free interpretation services offered by the MCO, the MCO shall have a process in place for informing the Member of the potential consequences of declination with the assistance of a competent interpreter to assure the Member's understanding, as well as a process to document the Member's declination.

4.4.7.4.12 Interpreter services shall be offered by the MCO at every new contact. Every declination requires new documentation by the MCO of the offer and decline.

4.4.7.4.13 The MCO shall comply with applicable provisions of federal laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, as amended, which prohibits the MCO from discriminating on the basis of race, color, or national origin.

4.4.7.4.14 As clarified by Executive Order 13166, Improving Access to Services for Persons with LEP, and resulting agency

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guidance, national origin discrimination includes discrimination on the basis of LEP. To ensure compliance with Title VI of the Civil Rights Act of 1964, the MCO shall take reasonable steps to ensure that LEP Members have meaningful access to the MCO's programs.

4.4.7.4.15 Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. The MCO is encouraged to consider the need for language services for LEP persons served or encountered both in developing their budgets and in conducting their programs and activities. Additionally, the MCO is encouraged to develop and implement a written language access plan to ensure it is prepared to take reasonable steps to provide meaningful access to each Member with LEP who may require assistance.

4.5 Member Grievances and Appeals

4.5.1 General Requirements

4.5.1.1 The MCO shall develop, implement and maintain a Grievance System under which Members may challenge the denial of coverage of, or payment for, medical assistance and which includes a Grievance Process, an Appeal Process, and access to the State's fair hearing system. [42 CFR 438.402(a); 42 CFR 438.228(a)] The MCO shall ensure that the Grievance System is in compliance with this Agreement, 42 CFR 438 Subpart F, State law as applicable, and NH Code of Administrative Rules, Chapter He-C 200 Rules of Practice and Procedure.

4.5.1.2 The MCO shall provide to DHHS a complete description, in writing and including all of its policies, procedures, notices and forms, of its proposed Grievance System for DHHS's review and approval during the Readiness Review period. Any proposed changes to the Grievance System shall be reviewed by DHHS thirty (30) calendar days prior to implementation.

4.5.1.3 The Grievance System shall be responsive to any grievance or appeal of Dual-Eligible Members. To the extent such grievance or appeal is related to a Medicaid service, the MCO shall handle the grievance or appeal in accordance with this Agreement.

4.5.1.4 In the event the MCO, after review, determines that the Dual-Eligible Member's grievance or appeal is solely related to a Medicare service, the MCO shall refer the Member to the State's Health Insurance Assistance Program (SHIP), which is currently administered by Service Link Aging and Disability Resource Center.

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4.5.1.5 The MCO shall be responsible for ensuring that the Grievance System (Grievance Process, Appeal Process, and access to the State's fair hearing system) complies with the following general requirements. The MCO shall:

4.5.1.5.1 Provide Members with all reasonable assistance in completing forms and other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability and assisting the Member in providing written consent for appeals [42 CFR 438.406(a); 42 CFR 438.228(a)];

4.5.1.5.2 Acknowledge receipt of each grievance and appeal (including oral appeals), unless the Member or authorized Provider requests expedited resolution [42 CFR 438.406(b)(1); 42 CFR 438.228(a)];

4.5.1.5.3 Ensure that decision makers on grievances and appeals and their subordinates were not involved in previous levels of review or decision making [42 CFR 438.406(b)(2)(i); 42 CFR 438.228(a)];

4.5.1.5.4 Ensure that decision makers take into account all comments, documents, records, and other information submitted by the Member or his or her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination [42 CFR 438.406(b)(2)(iii); 42 CFR 438.228(a)];

4.5.1.5.5 Ensure that, if deciding any of the following, the decision makers are health care professionals with clinical expertise in treating the Member's condition or disease:

4.5.1.5.5.1. An appeal of a denial based on lack of medical necessity;

4.5.1.5.5.2. A grievance regarding denial of expedited resolutions of an appeal; or

4.5.1.5.5.3. A grievance or appeal that involves clinical issues. [42 CFR 438.406(b)(2)(ii)(A) - (C); 42 CFR 438.228(a)].

4.5.1.5.6 Ensure that Members are permitted to file appeals and State fair hearings after receiving notice that an adverse action is upheld [42 CFR 438.402(c)(1); 42 CFR 438.408].

4.5.1.6 The MCO shall send written notice to Members and Participating Providers of any changes to the Grievance System at least thirty (30) calendar days prior to implementation.

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4.5.1.7 The MCO shall provide information as specified in 42 CFR 438.10(g) about the Grievance System to Providers and Subcontractors at the time they enter into a contract or Subcontract. The information shall include, but is not limited to:

4.5.1.7.1 The Member's right to file grievances and appeals and requirements and timeframes for filing;

4.5.1.7.2 The Member's right to a State fair hearing, how to obtain a hearing, and the rules that govern representation at a hearing;

4.5.1.7.3 The availability of assistance with filing;

4.5.1.7.4 The toll-free numbers to file oral grievances and appeals;

4.5.1.7.5 The Member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the MCO's action is upheld in a hearing, that the Member may be liable for the cost of any continued benefits; and

4.5.1.7.6 The Provider's right to appeal the failure of the MCO to pay for or cover a service.

4.5.1.8 The MCO shall make available training to Providers in supporting and assisting Members in the Grievance System.

4.5.1.9 The MCO shall maintain records of grievances and appeals, including all matters handled by delegated entities, for a period not less than ten (10) years. [42 CFR 438.416(a)]

4.5.1.10 At a minimum, such records shall include a general description of the reason for the grievance or appeal, the name of the Member, the dates received, the dates of each review, the dates of the grievance or appeal, the resolution and the date of resolution. [42 CFR 438.416(b)(1) - (6)]

4.5.1.11 In accordance with Exhibit O, the MCO shall provide reports on all actions related to Member grievances and appeals, including all matters handled by delegated entities, including timely processing, results, and frequency of grievance and appeals.

4.5.1.12 The MCO shall review Grievance System information as part of the State quality strategy and in accordance with this Agreement and 42 CFR 438.402. The MCO shall regularly review appeals data for process improvement which should include but not be limited to reviewing:

4.5.1.12.1 Reversed appeals for issues that could be addressed through improvements in the Prior Authorization process; and

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4.5.1.12.2 Overall appeals to determine further Member and Provider education in the Prior Authorization process.

4.5.1.13 The MCO shall make such information accessible to the State and available upon request to CMS. [42 CFR 438.416(c)]

4.5.2 Grievance Process

4.5.2.1 The MCO shall develop, implement, and maintain a Grievance Process that establishes the procedure for addressing Member grievances and which is compliant with RSA 420-J:5, 42 CFR 438 Subpart F and this Agreement.

4.5.2.2 The MCO shall permit a Member, or the Member's authorized representative with the Member's written consent, to file a grievance with the MCO either orally or in writing at any time. [42 CFR 438.402(c)(1)(i) - (ii); 42 CFR 438.408; 42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)]

4.5.2.3 The Grievance Process shall address Member's expression of dissatisfaction with any aspect of their care other than an adverse benefit determination. Subjects for grievances include, but are not limited to:

4.5.2.3.1 The quality of care or services provided;

4.5.2.3.2 Aspects of interpersonal relationships such as rudeness of a Provider or employee;

4.5.2.3.3 Failure to respect the Member's rights;

4.5.2.3.4 Dispute of an extension of time proposed by the MCO to make an authorization decision;

4.5.2.3.5 Members who believe that their rights established by RSA 135-C:56-57 or He-M 309 have been violated; and

4.5.2.3.6 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits in accordance with 42 CFR 438, subpart K.

4.5.2.4 The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance or within fifty-nine (59) calendar days of receipt of the grievance for grievances extended for up to fourteen (14) calendar days even if the MCO does not have all the information necessary to make the decision, for one hundred percent (100%) of Members filing a grievance. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]

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4.5.2.5 The MCO may extend the timeframe for processing a grievance by up to fourteen (14) calendar days:

4.5.2.5.1 If the Member requests the extension; or

4.5.2.5.2 If the MCO shows that there is need for additional information and that the delay is in the Member's interest (upon State request). [42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1)]

4.5.2.6 If the MCO extends the timeline for a grievance not at the request of the Member, the MCO shall:

4.5.2.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay; and

4.5.2.6.2 Give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1)]

4.5.2.7 [Amendment #6:] If the Member requests disenrollment, then the MCO shall resolve the grievance in time to permit the disenrollment (if approved) to be effective no later than the first day of the following second month in which the Member requests disenrollment. [42 CFR 438.56(d)(5)(ii); 42 CFR 438.56(e)(1); 42 CFR 438.228(a)]

4.5.2.8 The MCO shall notify Members of the resolution of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of resolution for clinical issues shall be in writing. [42 CFR 438.408(d)(1); 42 CFR 438.10]

4.5.2.9 Members shall not have the right to a State fair hearing in regard to the resolution of a grievance.

4.5.3 Appeal Process

4.5.3.1 The MCO shall develop, implement, and maintain an Appeal Process that establishes the procedure for addressing Member requests for review of any action taken by the MCO and which is in compliance with 42 CFR 438 Subpart F and this Agreement. The MCO shall have only one (1) level of appeal for Members. [42 CFR 438.402(b); 42 CFR 438.228(a)]

4.5.3.2 The MCO shall permit a Member, or the Member's authorized representative, or a Provider acting on behalf of the Member and with the Member's written consent, to request an appeal

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orally or in writing of any MCO action. [42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)]

4.5.3.3 The MCO shall include as parties to the appeal, the Member and the Member's authorized representative, or the legal representative of the deceased Member's estate. [42 CFR 438.406(b)(6)]

4.5.3.4 [Amendment #5:] The MCO shall permit a Member to file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the MCO's notice of action. [42 CFR 438.402(c)(2)(ii)] The MCO shall ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm these inquiries in writing, unless the Member or the authorized Provider requests expedited resolution. [42 CFR 438.406(b)(3)] ~~An oral request for an appeal shall be followed by a written and signed appeal request unless the request is for an expedited resolution. [42 CFR 438.402(c)(3)(ii)]~~

4.5.3.5 If DHHS receives a request to appeal an action of the MCO, DHHS shall forward relevant information to the MCO and the MCO shall contact the Member and acknowledge receipt of the appeal. [42 CFR 438.406(b)(1); 42 CFR 438.228(a)]

4.5.3.6 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

4.5.3.7 The MCO shall permit the Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing [42 CFR 438.406(b)(4)]. The MCO shall inform the Member of the limited time available for this in the case of expedited resolution.

4.5.3.8 [Amendment #10:] The MCO shall provide the Member and the Member's representative an opportunity to receive the Member's case file, including medical records, and any other documents and records considered during the Appeal Process free of charge prior to the resolution and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. [42 CFR 438.406(b)(5); 438.408(b) - (c)]

4.5.3.9 [Amendment #7:] The MCO may offer peer-to-peer review support, with a like clinician, upon request from a Member's Provider prior to the appeal decision. Any such peer-to-peer review should

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occur in a timely manner, and before the Provider seeks recourse through the Provider Appeal or State fair hearing process.

4.5.3.10 The MCO shall resolve one hundred percent (100%) of standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

4.5.3.11 The date of filing shall be considered either the date of receipt of an oral request for appeal or a written request for appeal from either the Member or Provider, whichever date is the earliest.

4.5.3.12 Members who believe the MCO is not providing mental health or Substance Use Disorder benefits, in violation of 42 CFR 42 CFR 438, subpart K, may file an appeal.

4.5.3.13 If the MCO fails to adhere to notice and timing requirements, established in 42 CFR 438.408, then the Member is deemed to have exhausted the MCO's appeals process, and the Member may initiate a State fair hearing. [42 CFR 438.408; 42 CFR 438.402(c)(1)(i)(A)].

4.5.4 Actions

4.5.4.1 The MCO shall permit the appeal of any action taken by the MCO. Actions shall include, but are not limited to the following:

4.5.4.1.1 Denial or limited authorization of a requested service, including the type or level of service;

4.5.4.1.2 Reduction, suspension, or termination of a previously authorized service;

4.5.4.1.3 Amendment #5: Denial, in whole or in part, of payment for a service, ~~except when denial for payment for a service is solely because the claim does not meet the definition of a "clean claim".~~ [42 CFR 438.400(b)(3)];

4.5.4.1.4 Failure to provide services in a timely manner, as defined by this Agreement;

4.5.4.1.5 Untimely service authorizations;

4.5.4.1.6 Failure of the MCO to act within the timeframes set forth in this Agreement or as required under 42 CFR 438 Subpart F and this Agreement; and

4.5.4.1.7 At such times, if any, that DHHS has an Agreement with fewer than two (2) MCOs, for a rural area resident with only one (1)

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MCO, the denial of a Member's request to obtain services outside the network, in accordance with 42 CFR 438.52(b)(2)(ii).

4.5.5 Expedited Appeal

4.5.5.1 The MCO shall develop, implement, and maintain an expedited appeal review process for appeals when the MCO determines, as the result of a request from the Member, or a Provider request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. [42 CFR 438.410(a)]

4.5.5.2 The MCO shall inform Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments sufficiently in advance of the resolution timeframe for expedited appeals. [42 CFR 438.406(b)(4); 42 CFR 438.408(b); 42 CFR 438.408(c)]

4.5.5.3 The MCO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the MCO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]

4.5.5.4 The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)] The MCO shall also make reasonable efforts to provide oral notice.

4.5.5.5 The date of filing of an expedited appeal shall be considered either an oral request for appeal or a written request from either the Member or Provider, whichever date is the earliest.

4.5.5.6 If the MCO extends the timeframes not at the request of the Member, it shall:

4.5.5.6.1 Make reasonable efforts to give the Member prompt oral notice of the delay by providing a minimum of three (3) oral attempts to contact the Member at various times of the day, on different days within two (2) calendar days of the MCO's decision to extend the timeframe as detailed in He-W 506.08(j);

4.5.5.6.2 Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and

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inform the Member of the right to file a grievance if he or she disagrees with that decision;

4.5.5.6.3 Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i) - (iii); 42 CFR 438.408(b)(2)-(3)]

4.5.5.7 The MCO shall meet the timeframes above for one hundred percent (100%) of requests for expedited appeals.

4.5.5.8 The MCO shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's appeal.

4.5.5.9 If the MCO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. [42 CFR 438.410(c); 42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2)]

4.5.5.10 The Member has a right to file a grievance regarding the MCO's denial of a request for expedited resolution. The MCO shall inform the Member of his/her right and the procedures to file a grievance in the notice of denial.

4.5.6 Content of Notices

4.5.6.1 The MCO shall notify the requesting Provider, and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. [42 CFR 438.210(c); 42 CFR 438.404] Such notice shall meet the requirements of 42 CFR 438.404, except that the notice to the Provider need not be in writing.

4.5.6.2 The MCO shall utilize NCQA compliant DHHS model notices for all adverse actions and appeals. MCO adverse action and appeal notices shall be submitted for DHHS review during the Readiness Review process. Each notice of adverse action shall contain and explain:

4.5.6.2.1 The action the MCO or its Subcontractor has taken or intends to take [42 CFR 438.404(b)(1)];

4.5.6.2.2 The reasons for the action, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action [42 CFR 438.404(b)(2)];

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4.5.6.2.3 The Member's or the Provider's right to file an appeal, including information on exhausting the MCO's one (1) level of appeal and the right to request a State fair hearing if the adverse action is upheld [42 CFR 438.404(b)(3); 42 CFR 438.402(b) - (c)];

4.5.6.2.4 Procedures for exercising Member's rights to file a grievance or appeal [42 CFR 438.404(b)(4)];

4.5.6.2.5 Circumstances under which expedited resolution is available and how to request it [42 CFR 438.404(b)(5)]; and

4.5.6.2.6 The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits [42 CFR 438.404(b)(6)].

4.5.6.3 The MCO shall ensure that all notices of adverse action be in writing and shall meet the following language and format requirements:

4.5.6.3.1 Written notice shall be translated for the Members who speak one (1) of the commonly encountered languages spoken by MCM Members (as defined by the State per 42 CFR 438.10(d));

4.5.6.3.2 Notice shall include language clarifying that oral interpretation is available for all languages and how to access it; and

4.5.6.3.3 Notices shall use easily understood language and format, and shall be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Members shall be informed that information is available in alternative formats and how to access those formats.

4.5.6.4 The MCO shall mail the notice of adverse action by the date of the action when any of the following occur:

4.5.6.4.1 The Member has died;

4.5.6.4.2 The Member submits a signed written statement requesting service termination;

4.5.6.4.3 The Member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that the service termination or reduction shall result;

4.5.6.4.4 The Member has been admitted to an institution where he or she is ineligible under the Medicaid State Plan for further services;

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4.5.6.4.5 The Member's address is determined unknown based on returned mail with no forwarding address;

4.5.6.4.6 The Member is accepted for Medicaid services by another state, territory, or commonwealth;

4.5.6.4.7 A change in the level of medical care is prescribed by the Member's physician;

4.5.6.4.8 The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or

4.5.6.4.9 The transfer or discharge from a facility shall occur in an expedited fashion. [42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); section 1919(e)(7) of the Social Security Act; 42 CFR 483.12(a)(5)(i); 42 CFR 483.12(a)(5)(ii)]

4.5.7 Timing of Notices

4.5.7.1 For termination, suspension or reduction of previously authorized Medicaid Covered Services, the MCO shall provide Members written notice at least ten (10) calendar days before the date of action, except the period of advance notice shall be no more than five (5) calendar days in cases where the MCO has verified facts that the action should be taken because of probable fraud by the Member. [42 CFR 438.404(c)(1); 42 CFR 431.211; 42 CFR 431.214]

4.5.7.2 In accordance with 42 CFR 438.404(c)(2), the MCO shall mail written notice to Members on the date of action when the adverse action is a denial of payment or reimbursement.

4.5.7.3 For standard service authorization denials or partial denials, the MCO shall provide Members with written notice as expeditiously as the Member's health condition requires but may not exceed fourteen (14) calendar days following a request for initial and continuing authorizations of services. [42 CFR 438.210(d)(1); 42 CFR 438.404(c)(3)] An extension of up to an additional fourteen (14) calendar days is permissible, if:

4.5.7.3.1 The Member, or the Provider, requests the extension; or

4.5.7.3.2 The MCO justifies a need for additional information and how the extension is in the Member's interest. [42 CFR 438.210(d)(1)(i)-(ii); 42 CFR 438.210(d)(2)(ii); 42 CFR 438.404(c)(4); 42 CFR 438.404(c)(6)]

4.5.7.4 When the MCO extends the timeframe, the MCO shall give the Member written notice of the reason for the decision to

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extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i)] Under such circumstance, the MCO shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii)]

4.5.7.5 For cases in which a Provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.5.7.6 The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the MCO justifies a need for additional information and how the extension is in the Member's interest.

4.5.7.7 The MCO shall provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. [42 CFR 438.404(c)(5)]

4.5.8 Continuation of Benefits

4.5.8.1 The MCO shall continue the Member's benefits if:

4.5.8.1.1 The appeal is filed timely, meaning on or before the later of the following:

4.5.8.1.1.1. Within ten (10) calendar days of the MCO mailing the notice of action, or

4.5.8.1.1.2. The intended effective date of the MCO's proposed action;

4.5.8.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4.5.8.1.3 The services was ordered by an authorized Provider;

4.5.8.1.4 The authorization period has not expired;

4.5.8.1.5 The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice; and

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4.5.8.1.6 The Member requests extension of benefits, orally or in writing. [42 CFR 438.420(a); 42 CFR 438.420(b)(1) - (5); 42 CFR 438.402(c)(2)(ii)]

4.5.8.2 If the MCO continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one (1) of the following occurs:

4.5.8.2.1 The Member withdraws the appeal, in writing;

4.5.8.2.2 The Member does not request a State fair hearing within ten (10) calendar days from when the MCO mails an adverse MCO decision regarding the Member's MCO appeal;

4.5.8.2.3 A State fair hearing decision adverse to the Member is made; or

4.5.8.2.4 The authorization expires or authorization service limits are met. [42 CFR 438.420(c)(1)-(3); 42 CFR 438.408(d)(2)]

4.5.8.3 If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the Member the amount paid for the services provided to the Member while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services. [42 CFR 438.420(d); 42 CFR 431.230(b)]

4.5.8.4 A Provider acting as an authorized representative shall not request a Member's continuation of benefits pending appeal even with the Member's written consent.

4.5.9 Resolution of Appeals

4.5.9.1 The MCO shall resolve each appeal and provide notice, as expeditiously as the Member's health condition requires, within the following timeframes:

4.5.9.1.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services, a decision shall be made within thirty (30) calendar days after receipt of the appeal even if the MCO does not have all the information necessary to make the decision, unless the MCO notifies the Member that an extension is necessary to complete the appeal.

4.5.9.1.2 The MCO may extend the timeframes up to fourteen (14) calendar days if:

4.5.9.1.2.1. The Member requests an extension, orally or in writing, or

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4.5.9.1.2.2. The MCO shows that there is a need for additional information and the MCO shows that the extension is in the Member's best interest; [42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1)]

4.5.9.1.3 If the MCO extends the timeframes not at the request of the Member then it shall:

4.5.9.1.3.1. Make reasonable efforts to give the Member prompt oral notice of the delay,

4.5.9.1.3.2. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. [42 CFR 438.408(c)(2)(i) - (ii); 42 CFR 438.408(b)(1); 42 CFR 438.408(b)(3)]

4.5.9.2 Under no circumstances may the MCO extend the appeal determination beyond forty-five (45) calendar days from the day the MCO receives the appeal request even if the MCO does not have all the information necessary to make the decision.

4.5.9.3 The MCO shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language.

4.5.9.4 The MCO shall include a written statement; in simple language, of the clinical rationale for the decision, including how the requesting Provider or Member may obtain the Utilization Management clinical review or decision-making criteria. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2)]

4.5.9.5 For notice of an expedited resolution, the MCO shall provide written notice, and make reasonable efforts to provide oral notice. [42 CFR 438.408(d)(2)(ii)]

4.5.9.6 For appeals not resolved wholly in favor of the Member, the notice shall:

4.5.9.6.1 Include information on the Member's right to request a State fair hearing;

4.5.9.6.2 How to request a State fair hearing;

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4.5.9.6.3 Include information on the Member's right to receive services while the hearing is pending and how to make the request; and

4.5.9.6.4 Inform the Member that the Member may be held liable for the amount the MCO pays for services received while the hearing is pending, if the hearing decision upholds the MCO's action. [42 CFR 438.408(d)(2)(i); 42 CFR 438.10; 42 CFR 438.408(e)(1) - (2)]

4.5.10 State Fair Hearing

4.5.10.1 The MCO shall inform Members regarding the State fair hearing process, including but not limited to Members' right to a State fair hearing and how to obtain a State fair hearing in accordance with its informing requirements under this Agreement and as required under 42 CFR 438 Subpart F.

4.5.10.2 The parties to the State fair hearing include the MCO as well as the Member and his or her representative or the representative of a deceased Member's estate.

4.5.10.3 The MCO shall ensure that Members are informed, at a minimum, of the following:

4.5.10.3.1 That Members shall exhaust all levels of resolution and appeal within the MCO's Grievance System prior to filing a request for a State fair hearing with DHHS; and

4.5.10.3.2 That if a Member does not agree with the MCO's resolution of the appeal, the Member may file a request for a State fair hearing within one hundred and twenty (120) calendar days of the date of the MCO's notice of the resolution of the appeal. [42 CFR.408(f)(2)]

4.5.10.4 If the Member requests a fair hearing, the MCO shall provide to DHHS and the Member, upon request; within three (3) business days, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.5 A Member may request an expedited resolution of a State fair hearing if the Administrative Appeals Unit (AAU) determines that the time otherwise permitted for a State fair hearing could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function, and:

4.5.10.5.1 The MCO adversely resolved the Member's appeal wholly or partially; or

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4.5.10.5.2 The MCO failed to resolve the Member's expedited appeal within seventy-two (72) hours and failed to extend the seventy-two (72)-hour deadline in accordance with 42 CFR 408(c) and He-W 506.08(i).

4.5.10.6 If the Member requests an expedited State fair hearing, the MCO shall provide to DHHS and the Member, upon request within twenty-four (24) hours, all MCO-held documentation related to the appeal, including but not limited to any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

4.5.10.7 If the AAU grants the Member's request for an expedited State fair hearing, then the AAU shall resolve the appeal within three (3) business days after the Unit receives from the MCO the case file and any other necessary information. [He-W 506.09(g)]

4.5.10.8 The MCO shall appear and defend its decision before the DHHS AAU. The MCO shall consult with DHHS regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and providing the Medical Director or other staff as appropriate, at no additional cost. In the event the State fair hearing decision is appealed by the Member, the MCO shall provide all necessary support to DHHS for the duration of the appeal at no additional cost.

4.5.10.9 The DHHS AAU shall notify the MCO of State fair hearing determinations. The MCO shall be bound by the fair hearing determination, whether or not the State fair hearing determination upholds the MCO's decision. The MCO shall not object to the State intervening in any such appeal.

4.5.11 Effect of Adverse Decisions of Appeals and Hearings

4.5.11.1 If the MCO or DHHS reverses a decision to deny, limit, or delay services that were not provided while the appeal or State fair hearing were pending, the MCO shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. [42 CFR 438.424(a)]

4.5.11.2 If the MCO or DHHS reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal or State fair hearing were pending, the MCO shall pay for those services. [42 CFR 438.424(b)]

4.5.12 Survival

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4.5.12.1 The obligations of the MCO to fully resolve all grievances and appeals, including but not limited to providing DHHS with all necessary support and providing a Medical Director or similarly qualified staff to provide evidence and testify at proceedings until final resolution of any grievance or appeal shall survive the termination of this Agreement.

4.6 Provider Appeals

4.6.1 **General**

4.6.1.1 The MCO shall develop, implement, and maintain a Provider Appeals Process under which Providers may challenge any Provider adverse action by the MCO, and access the State's fair hearing system in accordance with RSA 126-A:5, VIII.

4.6.1.2 The MCO shall provide to DHHS a complete description of its Provider Appeals Process, in writing, including all policies and procedures, notices and forms, of its proposed Provider Appeals Process for DHHS's review and approval during the Readiness Review period.

4.6.1.3 Any proposed changes to the Provider Appeals Process shall be approved by DHHS at least thirty (30) calendar days in advance of implementation.

4.6.1.4 The MCO shall clearly articulate its Provider Appeals Process in the MCO's Provider manual, and reference it in the Provider agreement.

4.6.1.5 The MCO shall ensure its Provider Appeals Process complies with the following general requirements:

4.6.1.5.1 Gives reasonable assistance to Providers requesting an appeal of a Provider adverse action;

4.6.1.5.2 Ensures that the decision makers involved in the Provider Appeals Process and their subordinates were not involved in previous levels of review or decision making of the Provider's adverse action;

4.6.1.5.3 Ensures that decision makers take into account all comments, documents, records, and other information submitted by the Provider to the extent such materials are relevant to the appeal; and

4.6.1.5.4 Advises Providers of any changes to the Provider Appeals Process at least thirty (30) calendar days prior to implementation.

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4.6.2 Provider Adverse Actions

4.6.2.1 The Provider shall have the right to file an appeal with the MCO and utilize the Provider Appeals Process for any adverse action, in accordance with RSA 126-A:5, VIII, except for Member appeals or grievances described in Section 4.5 (Member Grievances and Appeals). The Provider shall have the right to file an appeal within thirty (30) calendar days of the date of the MCO's notice of adverse action to the Provider. Reasons may include, but are not limited to:

4.6.2.1.1 Action against the Provider for reasons related to program integrity;

4.6.2.1.2 Termination of the Provider's agreement before the agreement period has ended for reasons other than when DHHS, MFCU or other government agency has required the MCO to terminate such agreement;

4.6.2.1.3 Denial of claims for services rendered that have not been filed as a Member appeal; and

4.6.2.1.4 Violation of the agreement between the MCO and the Provider.

4.6.2.2 The MCO shall not be precluded from taking an immediate adverse action even if the Provider requests an appeal; provided that, if the adverse action is overturned during the MCO's Provider Appeals Process or State fair hearing, the MCO shall immediately take all steps to reverse the adverse action within ten (10) calendar days.

4.6.3 Provider Appeal Process

4.6.3.1 The MCO shall provide written notice to the Provider of any adverse action, and include in its notice a description of the basis of the adverse action, and the right to appeal the adverse action.

4.6.3.2 Providers shall submit a written request for an appeal to the MCO, together with any evidence or supportive documentation it wishes the MCO to consider, within thirty (30) calendar days of:

4.6.3.2.1 The date of the MCO's written notice advising the Provider of the adverse action to be taken; or

4.6.3.2.2 The date on which the MCO should have taken a required action and failed to take such action.

4.6.3.3 The MCO shall be permitted to extend the decision deadline by an additional thirty (30) calendar days to allow the Provider to submit evidence or supportive documentation, and for other good cause determined by the MCO.

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4.6.3.4 The MCO shall ensure that all Provider Appeal decisions are determined by an administrative or clinical professional with expertise in the subject matter of the Provider Appeal.

4.6.3.5 The MCO may offer peer-to-peer review support, with a like clinician, upon request, for Providers who receive an adverse decision from the MCO. Any such peer-to-peer review should occur in a timely manner and before the Provider seeks recourse through the Provider Appeal or State fair hearing process.

4.6.3.6 The MCO shall maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period not less than ten (10) years. At a minimum, log records shall include:

4.6.3.6.1 General description of each appeal;

4.6.3.6.2 Name of the Provider;

4.6.3.6.3 Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and

4.6.3.6.4 Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

4.6.3.7 If the MCO fails to adhere to notice and timing requirements established in this Agreement, then the Provider is deemed to have exhausted the MCO's Appeals Process and may initiate a State fair hearing.

4.6.3.8 MCO Resolution of Provider Appeals

4.6.3.8.1 [Amendment 7] The MCO shall provide written notice of resolution of ~~the~~ ninety-five percent (95%) Provider appeal (Resolution Notice) within thirty (30) calendar days from either the date the MCO receives the appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which the Provider's evidence is received by the MCO.

4.6.3.8.2 The Resolution Notice shall include, without limitation:

4.6.3.8.2.1 The MCO's decision;

4.6.3.8.2.2 The reasons for the MCO's decision;

4.6.3.8.2.3 The Provider's right to request a State fair hearing in accordance with RSA 126-A:5, VIII; and

4.6.3.8.2.4 For overturned appeals, the MCO shall take all steps to reverse the adverse action within ten (10) calendar days.

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4.6.3.9 State Fair Hearing

4.6.3.9.1 The MCO shall inform its Participating Providers regarding the State fair hearing process consistent with RSA 126-A:5, VIII, including but not limited to how to obtain a State fair hearing in accordance with its informing requirements under this Agreement.

4.6.3.9.2 The parties to the State fair hearing include the MCO as well as the Provider.

4.6.3.9.3 The Participating Provider shall exhaust the MCO's Provider Appeals Process before pursuing a State fair hearing.

4.6.3.9.4 If a Participating Provider requests a State fair hearing, the MCO shall provide to DHHS and the Participating Provider, upon request, within three (3) business days, all MCO-held documentation related to the Provider Appeal, including but not limited to, any transcript(s), records, or written decision(s).

4.6.3.9.5 The MCO shall consult with DHHS regarding the State fair hearing process. In defense of its decisions in State fair hearing proceedings, the MCO shall provide supporting documentation, affidavits, and availability of the Medical Director and/or other staff as appropriate, at no additional cost.

4.6.3.9.6 The MCO shall appear and defend its decision before the DHHS AAU. Nothing in this Agreement shall preclude the MCO from representation by legal counsel.

4.6.3.9.7 The DHHS AAU shall notify the MCO of State fair hearing determinations within sixty (60) calendar days of the date of the MCO's Notice of Resolution.

4.6.3.9.8 The MCO shall:

4.6.3.9.8.1. Not object to the State intervening in any such appeal;

4.6.3.9.8.2. Be bound by the State fair hearing determination, whether or not the State fair hearing determination upholds the MCO's Final Determination; and

4.6.3.9.8.3. Take all steps to reverse any overturned adverse action within ten (10) calendar days.

4.6.3.9.9 Reporting

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4.6.3.9.9.1. The MCO shall provide to DHHS, as detailed in Exhibit O, Provider complaint and appeal logs. [42 CFR 438.66(c)(3)]

4.7 Access

4.7.1 **Provider Network**

4.7.1.1 The MCO shall implement written policies and procedures for selection and retention of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(a)]

4.7.1.2 The MCO shall develop and maintain a statewide Participating Provider network that adequately meets all covered medical, mental health, Substance Use Disorder and psychosocial needs of the covered population in a manner that provides for coordination and collaboration among multiple Providers and disciplines and Equal Access to services. In developing its network, the MCO shall consider the following:

4.7.1.2.1 Current and anticipated NH Medicaid enrollment;

4.7.1.2.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the covered NH population;

4.7.1.2.3 The number and type (in terms of training and experience and specialization) of Providers required to furnish the contracted services;

4.7.1.2.4 The number of network Providers limiting NH Medicaid patients or not accepting new or any NH Medicaid patients;

4.7.1.2.5 The geographic location of Providers and Members, considering distance, travel time, and the means of transportation ordinarily used by NH Members;

4.7.1.2.6 The linguistic capability of Providers to communicate with Members in non-English languages, including oral and American Sign Language;

4.7.1.2.7 The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions;

4.7.1.2.8 Adequacy of the primary care network to offer each Member a choice of at least two (2) appropriate PCPs that are accepting new Medicaid patients;

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4.7.1.2.9 Required access standards identified in this Agreement; and

4.7.1.2.10 Required access standards set forth by the NHID, including RSA. 420-J; and Admin Rule 2700.

4.7.1.3 The MCO shall meet the network adequacy standards included in this Agreement in all geographic areas in which the MCO operates for all Provider types covered under this Agreement.

4.7.1.4 The MCO shall ensure that services are as accessible to Members in terms of timeliness, amount, duration and scope as those that are available to Members covered by DHHS under FFS Medicaid within the same service area.

4.7.1.5 The MCO shall ensure Participating Providers comply with the accessibility standards of the ADA. Participating Providers shall demonstrate physical access, reasonable accommodations, and accessible equipment for all Members including those with physical or cognitive disabilities. [42 CFR 438.206(c)(3)]

4.7.1.6 The MCO shall demonstrate that there are sufficient Participating Indian Health Care Providers (IHCPs) in the Participating Provider network to ensure timely access to services for American Indians who are eligible to receive services. If Members are permitted by the MCO to access out-of-state IHCPs, or if this circumstance is deemed to be good cause for disenrollment, the MCO shall be considered to have met this requirement. [42 CFR 438.14(b)(1); 42 CFR 438.14(b)(5)]

4.7.1.7 The MCO shall maintain an updated list of Participating Providers on its website in a Provider Directory, as specified in Section 4.4.1.5 (Provider Directory) of this Agreement.

4.7.2 Assurances of Adequate Capacity and Services

4.7.2.1 The MCO's network shall have Participating Providers in sufficient numbers, and with sufficient capacity and expertise for all Covered Services to meet the geographic standards in Section 4.7.3 (Time and Distance Standards), the timely provision of services requirements in Section 4.7.5 (Timely Access to Service Delivery), Equal Access, and reasonable choice by Members to meet their needs [42 CFR 438.207(a)].

4.7.2.2 The MCO shall submit documentation to DHHS, in the format and frequency specified by DHHS in Exhibit O, that fulfills the following requirements:

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4.7.2.2.1 The MCO shall give assurances and provide supporting documentation to DHHS that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DHHS's standards for access and timeliness of care. [42 CFR 438.207(a); 42 CFR 438.68; 42 CFR 438.206(c)(1)].

4.7.2.2.2 The MCO offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Members for the service area. [42 CFR 438.207(b)(1)];

4.7.2.2.3 The MCO's Participating Provider network includes sufficient family planning Providers to ensure timely access to Covered Services. [42 CFR 438.206(b)(7)];

4.7.2.2.4 The MCO is complying with DHHS's requirements for availability, accessibility of services, and adequacy of the network including pediatric subspecialists as described in Section 4.7.5.10 (Access Standards for Children with Special Health Care Needs);

4.7.2.2.5 The MCO is complying with DHHS's requirements for Substance Use Disorder treatment services as specified in Section 4.11.6 (Substance Use Disorder) and mental health services as specified in Section 4.11.5 (Mental Health), including Providers required to reduce Psychiatric Boarding; and

4.7.2.2.6 The MCO demonstrates Equal Access to services for all populations in the MCM program, as described in Section 4.7.5 (Timely Access to Service Delivery).

4.7.2.3 To permit DHHS to determine if access to private duty nursing services is increasing, as indicated by DHHS in Exhibit O, the MCO shall provide to DHHS the following information:

4.7.2.3.1 The number of pediatric private duty nursing hours authorized by day/weekend/night, and intensive (ventilator dependent) modifiers; and

4.7.2.3.2 The number of pediatric private duty nursing hours delivered by day/weekend/night, and intensive (ventilator dependent) modifiers.

4.7.2.4 The MCO shall submit documentation to DHHS to demonstrate that it maintains an adequate network of Participating Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area, in accordance with Exhibit O:

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4.7.2.4.1 During the Readiness Review period, prior to the Program Start Date;

4.7.2.4.2 [Amendment #5:] Annually Semi-annually; and

4.7.2.4.3 At any time there has been a significant change (as defined by DHHS) in the entity's operations that would affect adequate capacity and services, including but not limited to changes in services, benefits, geographic service area, or payments; and/or enrollment of a new population in the MCO. [42 CFR 438.207(b) - (c)]

4.7.2.5 For purposes of providing assurances of adequate capacity and services, the MCO shall base the anticipated number of Members on the "NH MCM Fifty Percent (50%) Population Estimate by Zip Code" report provided by DHHS.

4.7.3 Time and Distance Standards

4.7.3.1 At a minimum, the MCO shall meet the geographic access standards described in the Table below for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members. [42 CFR 438.68(b)(1)(i) - (viii); 42 CFR 438.68(b)(3)]

Geographic Access Standards	
Provider/Service	Requirement
PCPs (Adult and Pediatric)	Two (2) within forty (40) driving minutes or fifteen (15) driving miles
Adult Specialists	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Pediatric Specialists	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
OB/GYN Providers	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospitals	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Mental Health Providers (Adult and Pediatric)	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
Pharmacies	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles

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Geographic Access Standards	
Provider/Service	Requirement
Tertiary or Specialized Services (Trauma, Neonatal, etc.)	One (1) within one hundred twenty (120) driving minutes or eighty driving (80) miles
Individual/Group MLADCs	One (1) within forty-five (45) minutes or fifteen (15) miles
Substance Use Disorder Programs	One (1) within sixty (60) minutes or forty-five (45) miles.
Adult Medical Day Care	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospice	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Office-based Physical Therapy/Occupational Therapy/Speech Therapy	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

4.7.3.2 [Amendment #5:] The MCO shall report annually ~~semi-annually~~ how specific provider types meet the time and distance standards for Members in each county within NH in accordance with Exhibit O.

4.7.3.3 DHHS shall continue to assess where additional access requirements, whether time and distance or otherwise, shall be incorporated (for example, to ensure appropriate access to home health services). DHHS may provide additional guidance to the MCO regarding its network adequacy requirements in accordance with Members' ongoing access to care needs.

4.7.3.3.1 [Amendment #8:] The MCO shall contract with qualified Substance Use Disorder Providers who request to join its Participating Provider network as defined in Sections 2.1.89 and 2.1.119.1 of this Agreement pending the Substance Use Disorder Provider's agreement to the terms of the MCO's contract.

4.7.3.4 Additional Provider Standards

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Provider/Service	Requirement
MLADCs	The MCO's Participating Provider Network shall include seventy percent (70%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Opioid Treatment Programs (OTPs)	The MCO's Participating Provider Network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Buprenorphine Prescribers	The Network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Residential Substance Use Disorder Treatment Programs	The Network shall include fifty percent (50%) of all such Providers licensed and practicing in NH and no less than two (2) in any public health region unless there are less than two (2) such Providers in the region
Peer Recovery Programs	The MCO's Participating Provider Network shall include one hundred percent (100%) of all such willing Programs in NH

4.7.4 Standards for Geographic Accessibility

4.7.4.1 The MCO may request exceptions from the above-identified network standards after demonstrating its efforts to create a sufficient network of Participating Providers to meet these standards. DHHS reserves the right to approve or disapprove these requests, at its discretion.

4.7.4.2 Should the MCO, after good faith negotiations with Provider(s), be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable, with the assistance of DHHS and after good faith negotiations, continue to be unable to meet geographic and timely access to service delivery standards, then for a period of up to sixty (60) calendar days after start date, Liquidated Damages, as described in Section 5.5.2 (Liquidated Damages) shall not apply.

4.7.4.3 Except within a period of sixty (60) calendar days after the start date where Liquidated Damages shall not apply, should the MCO, after good faith negotiations, be unable to create a sufficient number of Participating Providers to meet the geographic and timely access to service delivery standards, and should the MCO be unable,

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after good faith negotiations with the assistance of DHHS, continue to be unable to meet geographic and timely access to service delivery standards DHHS may, at its discretion, provide temporary exemption to the MCO from Liquidated Damages.

4.7.4.4 At any time the provisions of this section may apply, the MCO shall work with DHHS to ensure that Members have access to needed services.

4.7.4.5 The MCO shall ensure that an adequate number of participating physicians have admitting privileges at participating acute care hospitals in the Participating Provider network to ensure that necessary admissions can be made.

4.7.4.6 Exceptions

4.7.4.6.1 The MCO may request exceptions, via a Request for Exception, from the network adequacy standards after demonstrating its efforts to create a sufficient network of Participating Providers to meet these standards. [42 CFR 438.68(d)(1)] DHHS may grant the MCO an exception in the event that:

4.7.4.6.1.1. The MCO demonstrates that an insufficient number of qualified Providers or facilities that are willing to contract with the MCO are available to meet the network adequacy standards in this Agreement and as otherwise defined by the NHID and DHHS;

4.7.4.6.1.2. The MCO demonstrates, to the satisfaction of DHHS, that the MCO's failure to develop a Participating Provider network that meets the requirements is due to the refusal of a Provider to accept a reasonable rate, fee, term, or condition and that the MCO has taken steps to effectively mitigate the detrimental impact on covered persons; or

4.7.4.6.1.3. The MCO demonstrates that the required specialist services can be obtained through the use of telemedicine or telehealth from a Participating Provider that is a physician, physician assistant, nurse practitioner, clinic nurse specialist, nurse-midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, certified registered nurse anesthetist, or other behavioral health specialists licensed by the NH Board of Medicine. [RSA 167:4-d]

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4.7.4.7 The MCO is permitted to use telemedicine as a tool for ensuring access to needed services in accordance with telemedicine coverage policies reviewed and approved by DHHS, but the MCO shall not use telemedicine to meet the State's network adequacy standards unless DHHS has specifically approved a Request for Exception.

4.7.4.8 The MCO shall report on network adequacy and exception requests in accordance with Exhibit O.

4.7.5 Timely Access to Service Delivery

4.7.5.1 The MCO shall meet the following timely access standards for all Members, in addition to maintaining in its network a sufficient number of Participating Providers to provide all services and Equal Access to its Members.

4.7.5.2 The MCO shall make Covered Services available for Members twenty-four (24) hours a day, seven (7) days a week, when Medically Necessary. [42 CFR 438.206(c)(1)(iii)]

4.7.5.3 The MCO shall require that all Participating Providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial Members or are comparable to Medicaid FFS patients, if the Provider serves only Medicaid Members. [42 CFR 438.206(c)(1)(ii)].

4.7.5.4 The MCO shall encourage Participating Providers to offer after-hours office care in the evenings and on weekends.

4.7.5.5 The MCO's network shall meet minimum timely access to care and services standards as required per 42 CFR 438.206(c)(1)(i). Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.

4.7.5.6 The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

4.7.5.6.1 Non-Symptomatic Office Visits (i.e., preventive care) shall be available from the Member's PCP or another Provider within forty-five (45) calendar days.

4.7.5.6.2 A Non-Symptomatic Office Visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

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4.7.5.6.3 Non-Urgent, Symptomatic Office Visits (i.e., routine care) shall be available from the Member's PCP or another Provider within ten (10) calendar days. A Non-Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms not requiring immediate attention.

4.7.5.6.4 Urgent, Symptomatic Office Visits shall be available from the Member's PCP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.

4.7.5.6.5 Transitional Health Care shall be available from a primary care or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.6.6 Transitional Home Care shall be available with a home care nurse, licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or Specialty Care Provider or as part of the discharge plan.

4.7.5.7 [Amendment #7:] The MCO shall establish mechanisms to ensure that Participating Providers comply with the timely access standards. The MCO shall regularly monitor its network to determine compliance with timely access and shall provide an annual ~~a semi-annual~~ report to DHHS documenting its compliance with 42 CFR 438.206(c)(1)(iv) and (v), in accordance with Exhibit O.

4.7.5.8 The MCO shall monitor waiting times for obtaining appointments with approved CMH Programs and report case details on a semi-annual basis.

4.7.5.9 The MCO shall develop and implement a CAP if it or its Participating Providers fail to comply with timely access provisions in this Agreement in compliance with 42 CFR 438.206(c)(1)(vi).

4.7.5.10 Access Standards for Children with Special Health Care Needs

4.7.5.10.1 The MCO shall contract with specialists that have pediatric expertise where the need for pediatric specialty care significantly differs from adult specialty care.

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4.7.5.10.2 In addition to the "specialty care" Provider network adequacy requirements, the MCO shall contract with the following pediatric specialists:

- 4.7.5.10.2.1. Pediatric Critical Care;
- 4.7.5.10.2.2. Pediatric Child Development ;
- 4.7.5.10.2.3. Pediatric Genetics;
- 4.7.5.10.2.4. Pediatric Physical Medicine and Rehabilitation;
- 4.7.5.10.2.5. Pediatric Ambulatory Tertiary Care ;
- 4.7.5.10.2.6. Neonatal-Perinatal Medicine;
- 4.7.5.10.2.7. Pediatrics-Adolescent Medicine; and
- 4.7.5.10.2.8. Pediatric Psychiatry.

4.7.5.11 The MCO shall have adequate networks of pediatric Providers, sub-specialists, children's hospitals, pediatric regional centers and ancillary Providers to provide care to Children with Special Health Care Needs.

4.7.5.12 The MCO shall specify, in their listing of mental health and Substance Use Disorder Provider directories, which Providers specialize in children's services.

4.7.5.13 The MCO shall ensure that Members have access to specialty centers in and out of NH for diagnosis and treatment of rare disorders.

4.7.5.14 The MCO shall permit a Member who meets the definition of Children with Special Health Care Needs following plan enrollment and who requires specialty services to request approval to see a Non-Participating Provider to provide those services if the MCO does not have a Participating specialty Provider with the same level of expertise available.

4.7.5.15 The MCO shall develop and maintain a program for Children with Special Health Care Needs, which includes, but is not limited to methods for ensuring and monitoring timely access to pediatric specialists, subspecialists, ancillary therapists and specialized equipment and supplies; these methods may include standing referrals or other methods determined by the MCO.

4.7.5.16 The MCO shall ensure PCPs and specialty care Providers are available to provide consultation to DCYF regarding medical and

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psychiatric matters for Members who are children in State custody/guardianship.

4.7.5.17 Access Standards for Behavioral Health

4.7.5.17.1 The MCO shall have in its network the capacity to ensure that Transitional Health Care by a Provider shall be available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.

4.7.5.17.2 Emergency medical and behavioral health care shall be available twenty-four (24) hours a day, seven (7) days a week. Behavioral health care shall be available, and the MCO shall have in its network the capacity to ensure that waiting times for appointments and/or service availability do not exceed the following:

4.7.5.17.2.1. Within six (6) hours for a non-life threatening emergency;

4.7.5.17.2.2. Within forty-eight (48) hours for urgent care; and

4.7.5.17.2.3. Within ten (10) business days for a routine office visit appointment.

4.7.5.17.3 American Society of Addiction Medicine (ASAM) Level of Care

4.7.5.17.3.1. The MCO shall ensure Members timely access to care through a network of Participating Providers in each ASAM Level of Care. During the Readiness Review process and in accordance with Exhibit O:

4.7.5.17.3.1.1 The MCO shall submit a plan describing on-going efforts to continually work to recruit and maintain sufficient networks of Substance Use Disorder service Providers so that services are accessible without unreasonable delays; and

4.7.5.17.3.1.2 The MCO shall have a specified number of Providers able to provide services at each level of care required; if supply precludes compliance, the MCO shall notify DHHS and, within thirty (30) calendar days, submit an updated plan that identifies the specific steps that shall be taken

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to increase capacity, including milestones by which to evaluate progress.

4.7.5.18 The MCO shall ensure that Providers under contract to provide Substance Use Disorder services shall respond to inquiries for Substance Use Disorder services from Members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The Substance Use Disorder Provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the Member or referring agency, but not later than two (2) business days following the date of first contact.

4.7.5.19 The MCO shall ensure that Members who have screened positive for Substance Use Disorder services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment and no later than (3) business days after admission.

4.7.5.20 The MCO shall ensure that Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed until such a time that the Member is accepted and starts receiving services by the receiving agency. Members identified for partial hospitalization or rehabilitative residential services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business days from the date the ASAM Level of Care Assessment was completed.

4.7.5.21 If the type of service identified in the ASAM Level of Care Assessment is not available from the Provider that conducted the initial assessment within forty-eight (48) hours, the MCO shall ensure that the Provider provides interim Substance Use Disorder services until such a time that the Member starts receiving the identified level of care. If the type of service is not provided by the ordering Provider than the MCO is responsible for making a closed loop referral for that type of service (for the identified level of care) within fourteen (14) business days from initial contact and to provide interim Substance Use Disorder services until such a time that the Member is accepted and starts receiving services by the receiving agency.

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4.7.5.22 When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the Member's choice, Members being provided interim services shall be reassessed for ASAM level of care.

4.7.5.23 The MCO shall ensure that pregnant women are admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the MCO is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours, the MCO shall:

4.7.5.23.1 Assist the pregnant woman with identifying alternative Providers and with accessing services with these Providers. This assistance shall include actively reaching out to identify Providers on the behalf of the Member;

4.7.5.23.2 Provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week; Recovery support services as needed by the Member; and daily calls to the Member to assess and respond to any emergent needs.

4.7.5.24 Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.

4.7.6 Women's Health

4.7.6.1 The MCO shall provide Members with direct access to a women's health specialist within the network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].

4.7.6.2 The MCO shall provide access to Family Planning Services as defined in Section 2.1.47 (Definitions) to Members without the need for a referral or prior-authorization. Additionally, Members shall be able to access these services by Providers whether they are in or out of the MCO's network.

4.7.6.3 Enrollment in the MCO shall not restrict the choice of the Provider from whom the Member may receive Family Planning Services and supplies. [Section 1902(a)(23) of the Social Security Act; 42 CFR 431.51(b)(2)]

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4.7.6.4 The MCO shall only provide for abortions in the following situations:

4.7.6.4.1 If the pregnancy is the result of an act of rape or incest; or

4.7.6.4.2 In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition, caused by, or arising from, the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. [42 CFR 441.202; Consolidated Appropriations Act of 2008]

4.7.6.5 The MCO shall not provide abortions as a benefit, regardless of funding, for any reasons other than those identified in this Agreement.

4.7.7 Access to Special Services

4.7.7.1 The MCO shall ensure Members have access to DHHS-designated Level I and Level II Trauma Centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's service area or in close proximity to such service area. The MCO shall have written, out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a Trauma Center in its network.

4.7.7.2 The MCO shall ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, cranio-facial and congenital anomalies, home health agencies, and hospice programs. To the extent that the above specialty services are available within the State, the plan shall not exclude NH Providers from its network if the negotiated rates are commercially reasonable.

4.7.7.3 The MCO shall only pay for organ transplants when the Medicaid State Plan provides, and the MCO follows written standards that provide for similarly situated Members to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Members. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act]

4.7.7.4 The MCO may offer such tertiary or specialized services at so-called "centers of excellence". The tertiary or specialized services shall be offered within the New England region, if available.

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The MCO shall not exclude NH Providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.

4.7.8 Non-Participating Providers

4.7.8.1 If the MCO's network is unable to provide necessary medical, behavioral health or other services covered under the Agreement to a particular Member, the MCO shall adequately and in a timely manner cover these services for the Member through Non-Participating Providers, for as long as the MCO's Participating Provider network is unable to provide them. [42 CFR 438.206(b)(4)].

4.7.8.2 The MCO shall inform the Non-Participating Provider that the Member cannot be balance billed.

4.7.8.3 The MCO shall coordinate with Non-Participating Providers regarding payment utilizing a single case agreement. For payment to Non-Participating Providers, the following requirements apply:

4.7.8.3.1 If the MCO offers the service through a Participating Provider(s), and the Member chooses to access non-emergent services from a Non-Participating Provider, the MCO is not responsible for payment.

4.7.8.3.2 If the service is not available from a Participating Provider and the Member requires the service and is referred for treatment to a Non-Participating Provider, the payment amount is a matter between the MCO and the Non-Participating Provider.

4.7.8.4 The MCO shall ensure that cost to the Member is no greater than it would be if the service were furnished within the network [42 CFR 438.206(b)(5)].

4.7.9 Access to Providers During Transitions of Care

4.7.9.1 The MCO shall use a standard definition of "Ongoing Special Condition" which shall be defined as follows:

4.7.9.1.1 In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

4.7.9.1.2 In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

4.7.9.1.3 In the case of pregnancy, pregnancy from the start of the second trimester.

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4.7.9.1.4 In the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is six (6) months or less.

4.7.9.1.5 In the case of a child with Special Health Care Needs as defined in Section 4.10.3 (Priority Populations).

4.7.9.2 The MCO shall permit that, in the instances when a Member transitions into the MCO from FFS Medicaid, another MCO (including one that has terminated its agreement with DHHS) or another type of health insurance coverage and:

4.7.9.2.1 The Member is in ongoing course of treatment, has an Ongoing Special Condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), regardless of whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first;

4.7.9.2.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.2.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.3 The MCO shall permit that, in instances when a Member with an Ongoing Special Condition transitions into the MCO from FFS Medicaid or another MCO and at the time has a currently prescribed medication, the MCO shall cover such medications for ninety (90) calendar days from the Member's enrollment date or until the completion of a medical necessity review, whichever occurs first.

4.7.9.4 The MCO shall permit that, in instances in which a Provider in good standing leaves an MCO's network and:

4.7.9.4.1 The Member is in ongoing course of treatment, has a special condition (not including pregnancy or terminal illness), or is a Child with Special Health Care Needs, the Member is permitted to continue seeing his or her Provider(s), whether the Provider is a Participating or Non-Participating Provider, for up to ninety (90) calendar days;

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4.7.9.4.2 The Member is pregnant and in the second or third trimester, the Member may continue seeing her Provider(s), whether the Provider is a Participating or Non-Participating Provider, through her pregnancy and up to sixty (60) calendar days after delivery;

4.7.9.4.3 The Member is determined to be terminally ill at the time of the transition, the Member may continue seeing his or her Provider, whether the Provider is a Participating or Non-Participating Provider, for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

4.7.9.5 The MCO shall maintain a transition plan providing for Continuity of Care in the event of Agreement termination, or modification limiting service to Members, between the MCO and any of its contracted Providers, or in the event of site closing(s) involving a PCP with more than one (1) location of service. The transition plan shall describe how Members shall be identified by the MCO and how Continuity of Care shall be provided.

4.7.9.6 The MCO shall provide written notice of termination of a Participating Provider to all affected Members, defined as those who:

4.7.9.6.1 Have received services from the terminated Provider within the sixty (60)-day period immediately preceding the date of the termination; or

4.7.9.6.2 Are assigned to receive primary care services from the terminated Provider.

4.7.9.7 [Amendment #5:] The MCO shall make a good faith effort to give written notice of termination of a contracted provider, as follows:

4.7.9.7.1 [Amendment #5:] Written notice to DHHS, the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination; and

4.7.9.7.2 [Amendment #5:] Written notice to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, the later of:

4.7.9.7.2.1. [Amendment #5:] Thirty (30) calendar days prior to the effective date of the termination; or

4.7.9.7.2.2. [Amendment #5:] Fifteen (15) calendar days after receipt or issuance of the termination notice by the terminated provider.

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4.7.9.7.2.3. [Amendment #5:] The MCO shall have a transition plan in place for affected Members described in Section 4.7.9.7 within three (3) calendar days prior to the effective date of the termination.

~~[Base Contract:] notify DHHS and affected Members in writing of a Provider termination. The notice shall be provided by the earlier of: (1) fifteen (15) calendar days after the receipt or issuance of the termination notice, or (2) fifteen (15) calendar days prior to the effective date of the termination. Within three (3) calendar days prior to the effective date of the termination the MCO shall have a transition plan in place for all affected Members.~~

4.7.9.8 In addition to notification of DHHS of provider terminations, the MCO shall provide reporting in accordance with Exhibit O.

4.7.9.9 If a Member is in a prior authorized ongoing course of treatment with a Participating Provider who becomes unavailable to continue to provide services, the MCO shall notify the Member in writing within seven (7) calendar days from the date the MCO becomes aware of such unavailability and develop a transition plan for the affected Member.

4.7.9.10 If the terminated Provider is a PCP to whom the MCO Members are assigned, the MCO shall:

4.7.9.10.1 Describe in the notice to Members the procedures for selecting an alternative PCP;

4.7.9.10.2 Explain that the Member shall be assigned to an alternative PCP if they do not actively select one; and

4.7.9.10.3 Ensure the Member selects or is assigned to a new PCP within thirty (30) calendar days of the date of notice to the Member.

4.7.9.11 If the MCO is receiving a new Member it shall facilitate the transition of the Member's care to a new Participating Provider and plan a safe and medically appropriate transition if the Non-Participating Provider refuses to contract with the MCO.

4.7.9.12 The MCO shall actively assist Members in transitioning to a Participating Provider when there are changes in Participating Providers, such as when a Provider terminates its contract with the MCO. The Member's Care Management team shall provide this assistance to Members who have chronic or acute medical or behavioral health conditions, and Members who are pregnant.

4.7.9.13 To minimize disruptions in care, the MCO shall:

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4.7.9.13.1 With the exception of Members in their second or third trimester of pregnancy, provide continuation of the terminating Provider for up to ninety (90) calendar days or until the Member may be reasonably transferred to a Participating Provider without disruption of care, whichever is less; and

4.7.9.13.2 For Members in their second or third trimester of pregnancy, permit continued access to the Member's prenatal care Provider and any Provider currently treating the Member's chronic or acute medical or behavioral health condition or currently providing LTSS, through the postpartum period.

4.7.10 Second Opinion

4.7.10.1 The MCO shall provide for a Second Opinion from a qualified health care professional within the Participating Provider network, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member [42 CFR 438.206(b)(3)]. The MCO shall clearly state its procedure for obtaining a Second Opinion in its Member Handbook.

4.7.11 Provider Choice

4.7.11.1 The MCO shall permit each Member to choose his or her Provider to the extent possible and appropriate [42 CFR 438.3(l)].

4.8 Utilization Management

4.8.1 Policies and Procedures

4.8.1.1 The MCO's policies and procedures related to the authorization of services shall be in compliance with all applicable laws and regulations including but not limited to 42 CFR 438.210 and RSA Chapter 420-E.

4.8.1.2 The MCO shall ensure that the Utilization Management program assigns responsibility to appropriately licensed clinicians, including but not limited to physicians, nurses, therapists, and behavioral health Providers (including Substance Use Disorder professionals).

4.8.1.3 Amount, Duration, and Scope

4.8.1.3.1 The MCO shall ensure that each service provided to adults is furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under FFS Medicaid. [42 CFR 438.210(a)(2)]

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4.8.1.3.2 The MCO shall also provide services for Members under the age of twenty-one (21) to the same extent that services are furnished to individuals under the age of twenty-one (21) under FFS Medicaid. [42 CFR 438.210(a)(2)] Services shall be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. [42 CFR 438.210(a)(3)(i)]

4.8.1.3.3 Authorization duration for certain Covered Services shall be as follows:

4.8.1.3.3.1. Private duty nursing authorizations shall be issued for no less than six (6) months unless the Member is new to the private duty nursing benefit. Initial authorizations for Members new to the private duty nursing benefit shall be no less than two (2) weeks;

4.8.1.3.3.1.1 [Amendment #9] [Amendment #8:] [Amendment #7:] For the period January 1, 2022 through the end of the COVID-19 Public Health Emergency June 30-December 31, 2022, in an effort to ensure that Members receive timely, necessary, and appropriate medical care requiring covered private duty nursing services that might otherwise go unmet due to expired authorizations and to ensure that providers are not penalized for providing said timely, necessary and appropriate medical care, the MCO shall not deny a private duty nursing provider's reimbursement for covered services rendered up to forty-five (45) days after the service authorization expires.

4.8.1.3.3.2. Personal Care Attendant (PCA) authorizations shall be issued for no less that one (1) year unless the Member is new to the PCA benefit. Initial authorizations for Members new to the PCA benefit shall be no less than three (3) months.

4.8.1.3.3.3. Occupational therapy, physical therapy, and speech therapy authorizations that exceed the service limit of twenty (20) visits for each type of therapy shall be issued for no less than three (3) months initially. Subsequent authorizations for continuation of therapy services shall be issued for no less than six (6) months if the therapy is for habilitative purposes directed at functional impairments.

4.8.1.4 Written Utilization Management Policies

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4.8.1.4.1 The MCO shall develop, operate, and maintain a Utilization Management program that is documented through a program description and defined structures, policies, and procedures that are reviewed and approved by DHHS. The MCO shall ensure that the Utilization Management Program has criteria and policies that:

4.8.1.4.1.1. Are practicable, objective and based on evidence-based criteria, to the extent possible;

4.8.1.4.1.2. Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the MCO's service area, and are consistent with the Practice Guidelines described in Section 4.8.2 (Practice Guidelines and Standards);

4.8.1.4.1.3. Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (DHHS shall approve any changes to the clinical criteria before the criteria are utilized);

4.8.1.4.1.4. Are applied based on individual needs and circumstances (including social determinants of health needs);

4.8.1.4.1.5. Are applied based on an assessment of the local delivery system;

4.8.1.4.1.6. Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

4.8.1.4.1.7. Conform to the standards of NCQA Health Plan Accreditation as required by Section 4.12.2 (Health Plan Accreditation).

4.8.1.4.2 The MCO's written Utilization Management policies, procedures, and criteria shall describe the categories of health care personnel that perform utilization review activities and where they are licensed. Such policies, procedures and criteria shall address, at a minimum:

4.8.1.4.2.1. Second Opinion programs;

4.8.1.4.2.2. Pre-hospital admission certification;

4.8.1.4.2.3. Pre-inpatient service eligibility certification;

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4.8.1.4.2.4. Concurrent hospital review to determine appropriate length of stay;

4.8.1.4.2.5. The process used by the MCO to preserve confidentiality of medical information.

4.8.1.4.3 Clinical review criteria and changes in criteria shall be communicated to Participating Providers and Members at least thirty (30) calendar days in advance of the changes.

4.8.1.4.4 The Utilization Management Program descriptions shall be submitted by the MCO to DHHS for review and approval prior to the Program Start Date.

4.8.1.4.5 Thereafter, the MCO shall report on the Utilization Management Program as part of annual reporting in accordance with Exhibit O.

4.8.1.4.6 The MCO shall communicate any changes to Utilization Management processes at least thirty (30) calendar days prior to implementation.

4.8.1.4.7 The MCO's written Utilization Management policies, procedures, and criteria shall be made available upon request to DHHS, Participating Providers, and Members.

4.8.1.4.8 The MCO shall provide the Medical Management Committee (or the MCO's otherwise named committee responsible for medical Utilization Management) reports and minutes in accordance with Exhibit O. [42 CFR 438.66 (c)(7)]

4.8.1.5 Service Limit

4.8.1.5.1 The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity [42 CFR 438.210(a)(4)(i)]; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. [42 CFR 438.210(a)(4)(ii)(A)]

4.8.1.5.2 The MCO may place appropriate limits on a service for utilization control, provided:

4.8.1.5.2.1. The services supporting Members with ongoing or Chronic Conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports [42 CFR 438.210(a)(4)(ii)(B)]. This includes allowance for up to six (6) skilled nursing visits per benefit period without a Prior Authorization; and

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4.8.1.5.2.2. Family Planning Services are provided in a manner that protects and enables the Member's freedom to choose the method of Family Planning to be used. [42 CFR 438.210(a)(4)(ii)(C)]

4.8.1.6 Prior Authorization

4.8.1.6.1 The MCO and, if applicable, its Subcontractors shall have in place and follow written policies and procedures as described in the Utilization Management policies for processing requests for initial and continuing authorizations of services and including conditions under which retroactive requests shall be considered. Any Prior Authorization for Substance Use Disorder shall comply with RSA 420-J:17 and RSA 420-J:18 as described in Section 4.11.6.15 (Limitations on Prior Authorization Requirements). [42 CFR 438.210(b)(1)]

4.8.1.6.2 Authorizations shall be based on a comprehensive and individualized needs assessment that addresses all needs including social determinants of health and a subsequent person-centered planning process. [42 CFR 438.210(b)(2)(iii)] The MCO's Prior Authorization requirements shall comply with parity in mental health and Substance Use Disorder, as described in Section 4.11.4.4 (Restrictions on Treatment Limitations). [42 CFR 438.910(d)]

4.8.1.6.3 The MCO shall use the NH MCM standard Prior Authorization form. The MCO shall also work in good faith with DHHS, as initiated by DHHS, to develop other Prior Authorization forms with consistent information and documentation requirements from Providers wherever feasible. Providers shall be able to submit the Prior Authorizations forms electronically, by mail, or fax.

4.8.1.6.4 The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, including but not limited to interrater reliability monitoring, and consult with the requesting Provider when appropriate and at the request of the Provider submitting the authorization [42 CFR 438.210(b)(2)(i)-(ii)].

4.8.1.6.5 The MCO shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. [42 CFR 438.210(b)(3)]

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4.8.1.6.6 The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Member.

4.8.1.6.7 The MCO shall comply with all relevant federal regulations regarding inappropriate denials or reductions in care. [42 CFR 438.210(a)(3)(ii)]

4.8.1.6.8 The MCO shall issue written denial notices within timeframes specified by federal regulations and this Agreement.

4.8.1.6.9 The MCO shall permit Members to appeal service determinations based on the Grievance and Appeal Process required by federal law and regulations and this Agreement.

4.8.1.6.10 Compensation to individuals or entities that conduct Utilization Management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member. [42 CFR 438.210(e)]

4.8.1.6.11 Medicaid State Plan services and/or pharmaceutical Prior Authorizations, including those for specialty drugs, in place at the time a Member transitions to an MCO shall be honored for ninety (90) calendar days or until completion of a medical necessity review, whichever comes first.

4.8.1.6.12 The MCO shall, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.

4.8.1.6.13 Upon receipt of Prior Authorization information from DHHS, the new MCO shall honor Prior Authorizations in place by the former MCO as described in Section 4.7.9. (Access to Providers During Transitions of Care). The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 4.8.4.2 (Urgent Determinations and Covered/Extended Services).

4.8.1.6.14 [Amendment #9] Intentionally left blank. ~~The MCO shall also, in the Member Handbook, provide information to Members regarding Prior Authorization in the event the Member chooses to transfer to another MCO.~~

4.8.1.6.15 In the event that the Prior Authorization specifies a specific Provider, that MCO shall continue to utilize that Provider, regardless of whether the Provider is a Participating Provider, until such time as services are available in the MCO's network.

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4.8.1.6.16 The MCO shall ensure that the Member's needs are met continuously and shall continue to cover services under the previously issued Prior Authorization until the MCO issues new authorizations that address the Member's needs.

4.8.1.6.17 The MCO shall ensure that Subcontractors or any other party performing utilization review are licensed in NH in accordance with Section 3.14.2 (Contracts with Subcontractors).

4.8.1.6.18 [Amendment #8:] Beginning July 1, 2022, the MCO shall ensure that Subcontractors or any other party performing utilization reviews applicable to inpatient psychiatric treatment at New Hampshire Hospital and other State determined IMDs for mental illness, conduct authorization for services as follows:

4.8.1.6.18.1. [Amendment #8:] For a Member's initial admission, an automatic five (5) business days (excluding holidays) shall be authorized for the Member's initial involuntary emergency psychiatric admission to an IMD facility.

4.8.1.6.18.2. [Amendment #8:] Reauthorization of the Member's continuous admission, shall be rendered promptly within 24 hours of the request for reauthorization of the initial involuntary emergency psychiatric admission.

4.8.2 Practice Guidelines and Standards

4.8.2.1 The MCO shall adopt evidence-based clinical Practice Guidelines in compliance with 42 CFR 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines adopted by the MCO shall:

4.8.2.1.1 Be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field,

4.8.2.1.2 Consider the needs of the MCO's Members,

4.8.2.1.3 Be adopted in consultation with Participating Providers, and

4.8.2.1.4 Be reviewed and updated periodically as appropriate. [42 CFR 438.236(b)(1)-(3); 42 CFR 438.236(b)(4)]

4.8.2.2 The MCO shall develop Practice Guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

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4.8.2.3 The MCO shall adopt Practice Guidelines consistent with the standards of care and evidence-based practices of specific professional specialty groups, as identified by DHHS. These include, but are not limited to:

4.8.2.3.1 ASAM, as further described in Section 4.11.6.7 (Substance Use Disorder Clinical Evaluations and Treatment Plans);

4.8.2.3.2 The recommendations of the U.S. Preventive Services Task Force for the provision of primary and secondary care to adults, rated A or B;

4.8.2.3.3 The preventative services recommended by the AAP Bright Futures program; and

4.8.2.3.4 The Zero Suicide Consensus Guide for Emergency Departments²⁰

4.8.2.4 The MCO may substitute generally recognized, accepted guidelines to replace the U.S. Preventive Services Task Force and AAP Bright Futures program requirements, provided that the MCO meets all other Practice Guidelines requirements indicated within this Section 4.8.2 (Practice Guidelines and Standards) of the Agreement and that such substitution is reviewed by DHHS prior to implementation.

4.8.2.5 The MCO shall disseminate Practice Guidelines to DHHS and all affected Providers and make Practice Guidelines available, including but not limited to the MCO's website, and, upon request, to Members and potential Members. [42 CFR 438.236(c)]

4.8.2.6 The MCO's decisions regarding Utilization Management, Member education, and coverage of services shall be consistent with the MCO's clinical Practice Guidelines. [42 CFR 438.236(d)]

4.8.3 Medical Necessity Determination

4.8.3.1 The MCO shall specify what constitutes "Medically Necessary" services in a manner that:

4.8.3.1.1 Is no more restrictive than the NH DHHS FFS Medicaid program including quantitative and non-quantitative treatment limits, as indicated in State laws and regulations, the Medicaid State Plan, and other State policies and procedures [42 CFR 438.210(a)(5)(i)]; and

²⁰ Suicide Prevention Resource Center, "Care for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments"

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4.8.3.1.2 Addresses the extent to which the MCO is responsible for covering services that address [42 CFR 438.210(a)(5)(ii)(A)-(C)]:

4.8.3.1.2.1. The prevention, stabilization, diagnosis, and treatment of a Member's diseases, condition, and/or disorder that results in health impairments and/or disability;

4.8.3.1.2.2. The ability for a Member to achieve age-appropriate growth and development; and

4.8.3.1.2.3. The ability for a Member to attain, maintain, or regain functional capacity.

4.8.3.2 For Members twenty-one (21) years of age and older, "Medically Necessary" shall be as defined in Section 2.1.74.2 (Definitions).

4.8.3.3 For Members under twenty-one (21) years of age, per EPSDT, "Medically Necessary" shall be as defined in Section 2.1.74.1 (Definitions).

4.8.4 Notices of Coverage Determinations

4.8.4.1 The MCO shall provide the requesting Provider and the Member with written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.210(c) and 438.404.

4.8.4.2 Urgent Determinations and Continued/Extended Services

4.8.4.2.1 The MCO shall make Utilization Management decisions in a timely manner. The following minimum standards shall apply:

4.8.4.2.1.1. Urgent Determinations: Determination of an authorization involving urgent care shall be made as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the request for service for ninety-eight percent (98%) of requests, unless the Member or Member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. [42 CFR 438.210(d)(2)(i); 42 CFR 438.404(c)(6)]

4.8.4.2.1.2. In the case of such failure, the MCO shall notify the Member or Member's representative within twenty-four (24) hours of receipt of the request

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and shall advise the Member or Member's representative of the specific information necessary to make a determination.

4.8.4.2.1.3. The Member or Member's representative shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information.

4.8.4.2.1.4. Thereafter, notification of the benefit determination shall be made as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the MCO's receipt of the specified additional information; or the end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.2.1.5. Continued/Extended Services: The determination of an authorization involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity shall be made within twenty-four (24) hours of receipt of the request for ninety-eight percent (98%) of requests, provided that the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or course of treatment.

4.8.4.3 All Other Determinations

4.8.4.3.1 The determination of all other authorizations for pre-service benefits shall be made within a reasonable time period appropriate to the medical circumstances, but shall not exceed fourteen (14) calendar days for ninety-five percent (95%) of requests after the receipt of a request.

4.8.4.3.2 An extension of up to fourteen (14) calendar days is permissible for non-diagnostic radiology determinations if the Member or the Provider requests the extension, or the MCO justifies a need for additional information.

4.8.4.3.3 If an extension is necessary due to a failure of the Member or Member's representative to provide sufficient information to determine whether, or to what extent, benefits are covered as payable, the notice of extension shall specifically describe the required additional information needed, and the Member or Member's representative shall be given at least forty-five (45)

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calendar days from receipt of the notice within which to provide the specified information.

4.8.4.3.4 Notification of the benefit determination following a request for additional information shall be made as soon as possible, but in no case later than fourteen (14) calendar days after the earlier of:

4.8.4.3.4.1. The MCO's receipt of the specified additional information; or

4.8.4.3.4.2. The end of the period afforded the Member or Member's representative to provide the specified additional information.

4.8.4.3.4.3. When the MCO extends the timeframe, the MCO shall give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. Under such circumstance, the MCO shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

4.8.4.3.5 The determination of a post service authorization shall be made within thirty (30) calendar days of the date of filing. In the event the Member fails to provide sufficient information to determine the request, the MCO shall notify the Member within fifteen (15) calendar days of the date of filing, as to what additional information is required to process the request and the Member shall be given at least forty-five (45) calendar days to provide the required information.

4.8.4.3.6 The thirty (30) calendar day period for determination shall be tolled until such time as the Member submits the required information.

4.8.4.3.7 Whenever there is an adverse determination, the MCO shall notify the ordering Provider and the Member. For an adverse standard authorization decision, the MCO shall provide written notification within three (3) calendar days of the decision.

4.8.4.3.8 The MCO shall provide Utilization Management data to include but not be limited to timely processing, results, and frequency of service authorizations in accordance with Exhibit O.

4.8.5 Advance Directives

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4.8.5.1 The MCO shall adhere to all State and federal laws pertaining to Advance Directives including, but not limited to, RSA 137-J:21.

4.8.5.2 The MCO shall maintain written policies and procedures that meet requirements for Advance Directives in Subpart I of 42 CFR 489.

4.8.5.3 The MCO shall adhere to the definition of Advance Directives as defined in 42 CFR 489.100.

4.8.5.4 The MCO shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(a); 42 CFR 422.128(b); 42 CFR 489.102(a)]

4.8.5.5 The MCO shall educate staff concerning policies and procedures on Advance Directives. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)]

4.8.5.6 The MCO shall not condition the provision of care or otherwise discriminate against a Member or potential Member based on whether or not the Member has executed an Advance Directive. [42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(F); 42 CFR 489.102(a)(3)]

4.8.5.7 The MCO shall provide information in the Member Handbook with respect to how to exercise an Advance Directive, as described in Section 4.4.1.4 (Member Handbook). [42 CFR 438.10(g)(2)(xii); 42 CFR 438.3(j)]

4.8.5.8 The MCO shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. [42 CFR 438.3(j)(4)]

4.9 Member Education and Incentives

4.9.1 General Provisions

4.9.1.1 The MCO shall develop and implement evidenced-based wellness and prevention programs for its Members. The MCO shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by DHHS, including the National Diabetes Prevention Program. The MCO shall

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also participate in other public health initiatives at the direction of DHHS.

4.9.1.2 The MCO shall provide Members with general health information and provide services to help Members make informed decisions about their health care needs. The MCO shall encourage Members to take an active role in shared decision-making.

4.9.1.3 The MCO shall promote personal responsibility through the use of incentives and care management. The MCO shall reward Members for activities and behaviors that promote good health, health literacy and Continuity of Care. DHHS shall review and approve all reward activities proposed by the MCO prior to their implementation.

4.9.2 Member Health Education

4.9.2.1 The MCO shall develop and initiate a Member health education program that supports the overall wellness, prevention, and Care Management programs, with the goal of empowering patients to actively participate in their health care.

4.9.2.2 The MCO shall actively engage Members in both wellness program development and in program participation and shall provide additional or alternative outreach to Members who are difficult to engage or who utilize EDs inappropriately.

4.9.3 Member Cost Transparency

4.9.3.1 The MCO shall publish on its website and incorporate in its Care Coordination programs cost transparency information related to the relative cost of Participating Providers for MCO-selected services and procedures, with clear indication of which setting and/or Participating Provider is most cost-effective, referred to as "Preferred Providers."

4.9.3.2 The cost transparency information published by the MCO shall be related to select, non-emergent services, designed to permit Members to select between Participating Providers of equal quality, including the appropriate setting of care as assessed by the MCO. The services for which cost transparency data is provided may include, for example, services conducted in an outpatient hospital and/or ambulatory surgery center. The MCO should also include information regarding the appropriate use of EDs relative to low-acuity, non-emergent visits.

4.9.3.3 The information included on the MCO's website shall be accessible to all Members and also be designed for use specifically

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by Members that participate in the MCO's Reference-Based Pricing Incentive Program, as described in Section 4.9.4 (Member Incentive Programs) below.

4.9.4 Member Incentive Programs

4.9.4.1 The MCO shall develop at least one (1) Member Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as further described within this Section 4.9.4 (Member Incentive Programs) of the Agreement. The MCO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives of the MCOs and Providers described in Section 4.14 (Alternative Payment Models) of this Agreement as appropriate.

4.9.4.2 For all Member Incentive Programs developed, the MCO shall provide to participating Members that meet the criteria of the MCO-designed program cash or other incentives that:

4.9.4.2.1 May include incentives such as gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used for health-related purchases, gym memberships; and

4.9.4.2.2 Do not, in a given fiscal year for any one (1) Member, exceed a total monetary value of two hundred and fifty dollars (\$250.00).

4.9.4.3 The MCO shall submit to DHHS for review and approval all Member Incentive Program plan proposals prior to implementation

4.9.4.4 Within the plan proposal, the MCO shall include adequate assurances, as assessed by DHHS, that:

4.9.4.4.1 The program meets the requirements of 1112(a)(5) of the Social Security Act; and

4.9.4.4.2 The program meets the criteria determined by DHHS as described in Section 4.9.4.6 (Healthy Behavior Incentive Programs) and Section 4.9.4.7 (Reference-Based Pricing Incentive Programs) below.

4.9.4.5 The MCO shall report to DHHS, at least annually, the results of any Member Incentive Programs in effect in the prior twelve (12) months, including the following metrics and those indicated by DHHS, in accordance with Exhibit O:

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4.9.4.5.1 The number of Members in the program's target population, as determined by the MCO;

4.9.4.5.2 The number of Members that received any incentive payments, and the number that received the maximum amount as a result of participation in the program;

4.9.4.5.3 The total value of the incentive payments;

4.9.4.5.4 An analysis of the statistically relevant results of the program; and

4.9.4.5.5 Identification of goals and objectives for the next year informed by the data.

4.9.4.6 Healthy Behavior Incentive Programs

4.9.4.6.1 The MCO shall develop and implement at least one (1) Member Healthy Behavior Incentive Program designed to:

4.9.4.6.1.1. Incorporate incentives for Members who complete a Health Risk Assessment Screening, in compliance with Section 4.10.2 of this Agreement (Health Risk Assessment Screening);

4.9.4.6.1.2. Increase the timeliness of prenatal care, particularly for Members at risk of having a child with NAS;

4.9.4.6.1.3. Address obesity;

4.9.4.6.1.4. Prevent diabetes;

4.9.4.6.1.5. Support smoking cessation;

4.9.4.6.1.6. Increase lead screening rates in one- and two-year old Members; and/or

4.9.4.6.1.7. Other similar types of healthy behavior incentive programs in consultation with the Division of Public Health within DHHS and in alignment with the DHHS Quality Strategy and the MCO's QAPI, as described in Section 4.9.3 (Member Cost Transparency).

4.9.4.7 Reference-Based Pricing Incentive Programs

4.9.4.7.1 The MCO shall develop at least one (1) Reference-Based Pricing Member Incentive Program that encourages Members to use, when reasonable, Preferred Providers as assessed and indicated by the MCO and on its website in compliance with the

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Cost Transparency requirements included in Section 4.9.3 (Member Cost Transparency). The Reference-Based Pricing Member Incentive Program shall also include means for encouraging members' appropriate use of EDs and opportunities to direct Members to other settings for low acuity, non-emergent visits.

4.9.4.7.2 The MCO's Reference-Based Pricing Member Incentive Program shall be designed such that the Member may gain and lose incentives (e.g., through the development of a points system that is monitored throughout the year) based on the Member's adherence to the terms of the program throughout the course of the year.

4.9.5 Collaboration with New Hampshire Tobacco Cessation Programs

4.9.5.1 [Amendment #7:] The MCO shall promote and utilize the DHHS-approved tobacco treatment quitline, 1-800-QUITNOW (1-800-784-8669) ~~cessation quitline and tobacco cessation program~~ to provide:

4.9.5.1.1 Intensive tobacco cessation treatment through a DHHS-approved tobacco cessation quitline;

4.9.5.1.2 Individual tobacco cessation coaching/counseling in conjunction with tobacco cessation medication;

4.9.5.1.3 The following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by DHHS; and

4.9.5.1.4 Combination therapy, when available through quitline, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy (gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release.

4.9.5.2 The MCO shall provide tobacco cessation treatment to include, at a minimum:

4.9.5.2.1 Tobacco cessation coaching/counseling in addition to the quitline;

4.9.5.2.2 In addition to the quitline, the following FDA-approved over-the-counter agents: nicotine patch; nicotine gum; nicotine lozenge; and any future FDA-approved therapies, as indicated by DHHS;

4.9.5.2.3 In addition to the quitline, Combination therapy, meaning the use of a combination of medicines, including but not limited to: long-term nicotine patch and other nicotine replacement therapy

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(gum or nasal spray); nicotine patch and inhaler; or nicotine patch and bupropion sustained-release;

4.9.5.2.4 Rebateable FDA-approved non-nicotine prescription medications; and

4.9.5.2.5 Rebateable FDA-approved prescription inhalers and nasal sprays.

4.9.5.3 The MCO shall report on tobacco cessation activities in accordance with Exhibit O.

4.10 Care Coordination and Care Management

4.10.1 Care Coordination and Care Management General Requirements

4.10.1.1 The MCO shall be responsible for the management, coordination, and Continuity of Care for all Members, and shall develop and maintain policies and procedures to address this responsibility.

4.10.1.2 The MCO shall implement Care Coordination and Care Management procedures to ensure that each Member has an ongoing source of care appropriate to their needs. [42 CFR 438.208(b)]

4.10.1.3 The MCO shall provide the services described in this Section 4.10 (Care Coordination and Care Management) for all Members who need Care Coordination and Case Management services regardless of their acuity level.

4.10.1.4. [Amendment #2:] The MCO shall either provide these services directly or shall Subcontract with Local Care Management ~~Networks—entities~~ as described in Section 4.10.8 (Local Care Management) to perform Care Coordination and Care Management functions.

4.10.1.5 [Amendment #2:] Care Coordination means the interaction with established local community-based Providers of care including Local Care Management ~~Networks—entities~~ to address the physical, mental and psychosocial needs of the Member.

4.10.1.6 Care Management means direct contact with a Member focused on the provision of various aspects of the Member's physical, mental, Substance Use Disorder status and needed social supports that shall enable the Member in achieving the best health outcomes.

4.10.1.7 The MCO shall implement Care Coordination and Care Management in order to achieve the following goals:

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- 4.10.1.7.1 Improve care of Members;
- 4.10.1.7.2 Improve health outcomes;
- 4.10.1.7.3 Reduce inpatient hospitalizations including readmissions;
- 4.10.1.7.4 Improve Continuity of Care;
- 4.10.1.7.5 Improve transition planning;
- 4.10.1.7.6 Improve medication management;
- 4.10.1.7.7 Reduce utilization of unnecessary Emergency Services;
- 4.10.1.7.8 Reduce unmet resource needs (related to social determinants of health);
- 4.10.1.7.9 Decrease total costs of care; and
- 4.10.1.7.10 Increase Member satisfaction with their health care experience.

4.10.1.8 The MCO shall implement and oversee a process that ensures its Participating Providers coordinate care among and between Providers serving a Member, including PCPs, specialists, behavioral health Providers, and social service resources; the process shall include, but not be limited to, the designation of a Care Manager who shall be responsible for leading the coordination of care.

4.10.1.9 The MCO shall implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives from any other MCO. [42 CFR 438.208(b)(2)(ii)]

4.10.1.10 The MCO shall also implement procedures to coordinate services the MCO furnishes to the Member with the services the Member receives in FFS Medicaid, including dental services for children under the age of twenty-one (21). [42 CFR 438.208(b)(2)(iii)]

4.10.1.11 [Amendment #9:] The MCO shall provide care coordination support for Members who require services not covered by this Agreement as they may receive services through other appropriate Medicaid, commercial, or government health insurance programs. In such cases, the MCO's responsibility shall include coordination and referrals in compliance with 42 CFR 438.208(b)(2)(iii)-(iv).

4.10.2 Health Risk Assessment Screening

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4.10.2.1 The Health Risk Assessment Screening process shall identify the need for Care Coordination and Care Management services and the need for clinical and non-clinical services including referrals to specialists and community resources.

4.10.2.2 The MCO shall conduct a Health Risk Assessment Screening of all existing and newly enrolled Members within ninety (90) calendar days of the effective date of MCO enrollment to identify Members who may have unmet health care needs and/or Special Health Care Needs [42 CFR 438.208(c)(1)]:

4.10.2.3 The MCO is not required to conduct a Health Risk Assessment Screening of Members residing in a nursing facility more than one hundred (100) consecutive calendar days.

4.10.2.4 The Health Risk Assessment shall be the same for each MCO. The agreed upon screening tool developed jointly by the MCOs shall be submitted to DHHS for review and approval, as part of the Readiness Review process, and annually thereafter.

4.10.2.5 The Health Risk Assessment Screening may be conducted by telephone, in person, or through completion of the form in writing by the Member. The MCO shall make at least three (3) reasonable attempts to contact a Member at the phone number most recently reported by the Member. [42 CFR 438.208(b)(3)]

4.10.2.6 Documentation of the three (3) attempts shall be included in the MCO electronic Care Management record. Reasonable attempts shall occur on not less than three (3) different calendar days, at different hours of the day including day and evening hours and after business hours. If after the three (3) attempts are unsuccessful, the MCO shall send a letter to the Member's last reported residential address with the Health Risk Assessment form for completion.

4.10.2.7 [Amendment #8:] [Amendment #2:] The MCO may also Subcontract with a Designated Local Care Management Network Entity, community-based agency or a primary care practice who shall engage the Member to complete the Health Risk Assessment screening either telephonically or in-person either in an agency office/clinic setting, during a scheduled home visit or medical appointment.

4.10.2.8 All completed Health Risk Assessments shall be shared with the Member's assigned PCP for inclusion in the Member's medical record and within seven (7) calendar days of completing the screening.

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4.10.2.9 The MCO shall report the number of Members who received a Health Risk Assessment, in accordance with Exhibit O.

4.10.2.10 The MCO shall share with DHHS and/or other MCOs the results of any identification and assessment of that Member's needs to prevent duplication of activities. [42 CFR 438.208(b)(4)]

4.10.2.11 The MCO shall report to DHHS its performance against Health Risk Assessment requirements, as described in Exhibit O.

4.10.2.12 ~~[Amendment #8:] [Amendment #5:] The MCO shall ensure Member Health Risk Assessment completion for Members shall be completed for at least twenty-five percent (25%) fifty percent (50%) of the plan's total required Members to be considered eligible for a performance based award described in the Performance-Based Auto-Assignment Guidance, or the MCO shall provide to DHHS for review and approval additional documentation that describes the MCO's reasoning for failure to successfully complete Health Risk Assessments for fifty percent (50%) of Members. The MCO's reasoning shall be considered by DHHS prior to imposing Liquidated Damages, as described in Section 5.5.2 of this Agreement.~~

4.10.2.13 The evidence-based Health Risk Assessment Screening tool shall identify, at minimum, the following information about Members:

4.10.2.13.1 Demographics;

4.10.2.13.2 Chronic and/or acute conditions;

4.10.2.13.3 Chronic pain;

4.10.2.13.4 The unique needs of children with developmental delays, Special Health Care Needs or involved with the juvenile justice system and child protection agencies (i.e. DCYF);

4.10.2.13.5 Behavioral health needs, including depression or other Substance Use Disorders as described in sections, including but not limited to Section 4.11.1.16 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.11.5.4 (Comprehensive Assessment and Care Plans), and Section 4.11.6.6 (Provision of Substance Use Disorder Services);

4.10.2.13.6 The need for assistance with personal care such as dressing or bathing or home chores and grocery shopping;

4.10.2.13.7 Tobacco Cessation needs;

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4.10.2.13.8 Social determinants of health needs, including housing, childcare, food insecurity, transportation and/or other interpersonal risk factors such as safety concerns/caregiver stress; and

4.10.2.13.9 Other factors or conditions about which the MCO shall need to be aware to arrange available interventions for the Member.

4.10.2.14 Wellness Visits

4.10.2.14.1 For all Members, inclusive of Granite Advantage Members, the MCO shall support the Member to arrange a wellness visit with his or her PCP, either previously identified or selected by the Member from a list of available PCPs.

4.10.2.14.2 The wellness visit shall include appropriate assessments for the purpose of developing a health, wellness and care plan:

4.10.2.14.2.1. Both physical and behavioral health, including screening for depression;

4.10.2.14.2.2. Mood, suicidality; and

4.10.2.14.2.3. Substance Use Disorder.

4.10.3 Priority Populations

4.10.3.1 The following populations shall be considered Priority Populations and are most likely to have Care Management needs:

4.10.3.1.1 Adults with Special Health Care Needs, meaning those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, acquired brain disorder, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for Members of similar age.

4.10.3.1.1.1. This includes, but is not limited to Members with HIV/AIDS, an SMI, SED, I/DD or Substance Use Disorder diagnosis, or with chronic pain;

4.10.3.1.2 Children with Special Health Care Needs meaning those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age.

4.10.3.1.2.1. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with NAS; in high stress

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social environments/caregiver stress; receiving Family Centered Early Supports and Services, or participating in Special Medical Services or Partners in Health Services with an SED, I/DD or Substance Use Disorder diagnosis;

4.10.3.1.3 Members receiving services under HCBS waivers;

4.10.3.1.4 Members identified as those with rising risk. The MCO shall establish criteria that define Members at rising risk for approval by DHHS as part of the Readiness Review process and reviewed and approved annually;

4.10.3.1.5 Individuals with high unmet resources needs meaning MCM Members who are homeless; experiencing domestic violence or perceived lack of personal safety; and/or demonstrate unmet resource needs as further described in Section 4.10.10 (Coordination and Integration with Social Services and Community Care);

4.10.3.1.5.1. Recently incarcerated;

4.10.3.1.5.2. Mothers of babies born with NAS;

4.10.3.1.5.3. Pregnant women with Substance Use Disorders;

4.10.3.1.5.4. IV Drug Users, including Members who require long-term IV antibiotics and/or surgical treatment as a result of IV drug use;

4.10.3.1.5.5. Members who have been in the ED for an overdose event in the last twelve (12) months;

4.10.3.1.5.6. Members who have a suicide attempt in the last twelve (12) months;

4.10.3.1.5.7. Members with an I/DD diagnosis; and/or

4.10.3.1.5.8. Other Priority Populations as determined by the MCO and/or by DHHS.

4.10.4 Risk Scoring and Stratification

4.10.4.1 The MCO shall use a Risk Scoring and Stratification methodology to identify Members who are part of a Priority Population or who are otherwise high risk/high need for Care Management and who should receive a Comprehensive Assessment.

4.10.4.2 The MCO shall provide protocols to DHHS for review and approval on how Members are stratified by severity and risk level,

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including details regarding the algorithm and data sources used to identify Members eligible for Care Management.

4.10.4.3 Such protocols shall be submitted as part of the Readiness Review process and annually thereafter.

4.10.4.4 Risk Scoring and Stratification of Members should be conducted at MCO program roll out and monthly thereafter.

4.10.4.5 The MCO's Risk Scoring and Stratification methodology shall take into account, at a minimum, the following information:

4.10.4.5.1 Results of the health risk assessment screening;

4.10.4.5.2 Claims history and Encounter Data;

4.10.4.5.3 Pharmacy data;

4.10.4.5.4 Immunizations;

4.10.4.5.5 ADT of Members to and from inpatient facilities;

4.10.4.5.6 Provider referral;

4.10.4.5.7 Member self-referral;

4.10.4.5.8 Hospital stays of more than two (2) weeks;

4.10.4.5.9 Members without secure and stable housing post hospital discharge;

4.10.4.5.10 Three (3) or more ED visits within a single calendar quarter;

4.10.4.5.11 Discharge from inpatient Behavioral Health Services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center; and

4.10.4.5.12 Neonatal Intensive Care Unit discharges.

4.10.4.6 The MCO shall document and submit to DHHS for review and approval the details of its Risk Scoring and Stratification methodology as part of its Readiness Review and annually thereafter. This submission shall include:

4.10.4.6.1 Information and data to be utilized;

4.10.4.6.2 Description of the methodology;

4.10.4.6.3 Methodology and Criteria for identifying high risk/high need Members in addition to those who are in Priority Populations;

4.10.4.6.4 Number of risk strata;

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4.10.4.6.5 Criteria for each risk stratum, including but not limited to high risk/high need members in need of Care Management; and

4.10.4.6.6 Approximate expected population in each stratum.

4.10.4.7 The MCO shall submit any change in its risk stratification methodologies, to include any additions or deletions to that methodology, for DHHS review ninety (90) calendar days prior to the change being implemented.

4.10.4.8 The MCO shall report annually the number and percentage of Members who are identified in each of the risk strata in accordance with Exhibit O.

4.10.5 Comprehensive Assessment for High-Risk and High-Need Members

4.10.5.1 The MCO and its Subcontractors shall implement mechanisms to conduct a Comprehensive Assessment for each Medicaid Member in order to identify whether they have Special Health Care Needs and any on-going special conditions that require a course of treatment or regular care monitoring. [42 CFR 438.208(c)(2)]

4.10.5.2 The MCO shall identify Members who may require a Comprehensive Assessment for Care Management through multiple sources to include but not be limited to:

4.10.5.2.1 Health risk assessment screenings;

4.10.5.2.2 Risk Scoring and Stratification;

4.10.5.2.3 Claims/encounter analysis;

4.10.5.2.4 Provider referrals;

4.10.5.2.5 Member/caregiver self-referral; and

4.10.5.2.6 Referrals from community based medical, mental health, Substance Use Disorder Providers, or social service entities.

4.10.5.3 The Comprehensive Assessment shall identify a Member's health condition that requires a course of treatment that is either episodic, which is limited in duration or significance to a particular medical episode,

or requires ongoing Care Management monitoring to ensure the Member is managing his or her medical and/or behavioral health care needs (including screening for depression, mood, suicidality, and Substance Use Disorder).

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4.10.5.4 The Comprehensive Assessment shall be a person-centered assessment of a Member's medical and behavioral care needs, functional status, accessibility needs, strengths and supports, health care goals and other characteristics that shall inform whether the Member should receive Care Management and shall inform the Member's ongoing care plan and treatment. The MCO shall incorporate into the Comprehensive Assessment information obtained as a result of Provider referral, the wellness visit and/or otherwise.

4.10.5.5 The MCO's Comprehensive Assessment tool shall be submitted for DHHS review and approval as part of the Readiness Review process and annually thereafter.

4.10.5.6 The MCO shall make best efforts to complete the Comprehensive Assessment within thirty (30) calendar days of identifying a Member as being part of one or more Priority Populations, identified through Risk Scoring and Stratification or having received a referral for Care Management.

4.10.5.7 The MCO shall not withhold any Medically Necessary Services including EPSDT services per Section 4.1.8 (Early and Periodic Screening, Diagnostic, and Treatment) for Members while awaiting the completion of the Comprehensive Assessment but may conduct utilization review for any services requiring Prior Authorization.

4.10.5.8 The MCO shall conduct the Comprehensive Assessment in a location of the Member's choosing and shall endeavor to conduct the Comprehensive Assessment in-person for populations where the quality of information may be compromised if provided telephonically (e.g., for Members whose physical or behavioral health needs may impede the ability to provide comprehensive information by telephone), including others in the person's life in the assessment process such as family members, paid and natural supports as agreed upon and appropriate to the Member/Member's parents to the maximum extent practicable.

4.10.5.9 Additionally, participation in the Comprehensive Assessment shall be extended to the Member's local community care team or Case Management staff, including but not limited to Area Agencies, CFI waiver, CMH Programs and Special Medical Services 1915(i) Care Management Entities/case managers as practicable.

4.10.5.10 The MCO shall develop and implement a Comprehensive Assessment tailored to Members that include, at a minimum, the following domains/content:

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- 4.10.5.10.1 Members' immediate care needs;
 - 4.10.5.10.2 Demographics;
 - 4.10.5.10.3 Education;
 - 4.10.5.10.4 Housing;
 - 4.10.5.10.5 Employment and entitlements;
 - 4.10.5.10.6 Legal involvement;
 - 4.10.5.10.7 Risk assessment, including suicide risk;
 - 4.10.5.10.8 Other State or local community and family support services currently used;
 - 4.10.5.10.9 Medical and other health conditions;
 - 4.10.5.10.10 Physical, I/DDs;
 - 4.10.5.10.11 Functional status (activities of daily living (ADL)/instrumental activities of daily living, (IADL)) including cognitive functioning;
 - 4.10.5.10.12 Medications;
 - 4.10.5.10.13 Available informal, caregiver, or social supports, including peer supports;
 - 4.10.5.10.14 Current and past mental health and substance use status and/or disorders;
 - 4.10.5.10.15 Social determinants of health needs; and
 - 4.10.5.10.16 Exposure to adverse childhood experiences or other trauma (e.g., parents with mental health or Substance Use Disorders that affect their ability to protect the safety of the child, child abuse or neglect).
- 4.10.5.11 The MCO shall provide to DHHS a copy of the Comprehensive Assessment Form and all policies and procedures relating to conducting the Comprehensive Assessment for DHHS review as part of the Readiness Review process and annually thereafter.
- 4.10.5.12 The MCO shall conduct a re-assessment of the Comprehensive Assessment for a Member receiving ongoing care management:
- 4.10.5.12.1 At least annually;
 - 4.10.5.12.2 When the Member's circumstances or needs change significantly;

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4.10.5.12.3 At the Member's request; and/or

4.10.5.12.4 Upon DHHS's request.

4.10.5.13 The MCO shall share the results of the Comprehensive Assessment in writing with the Member's local community based care team within fourteen (14) calendar days to inform care planning and treatment planning, with Member consent to the extent required by State and federal law.

4.10.5.14 The MCO shall report to DHHS the following in accordance with Exhibit O:

4.10.5.14.1 Assessments conducted as a percentage (%) of total Members and by Priority Population category;

4.10.5.14.2 Assessments completed by a Subcontractor entity, such as but not limited to IDNs, CMH Programs, Special Medical Services, HCBS case managers, and Area Agencies;

4.10.5.14.3 Timeliness of assessments;

4.10.5.14.4 Timeliness of dissemination of assessment results to PCPs, specialists, behavioral health Providers and other members of the local community based care team; and

4.10.5.14.5 Quarterly report of unmet resource needs, aggregated by county, based on the care screening and Comprehensive Assessment tool to include number of Members reporting in accordance with Exhibit O.

4.10.6 Care Management for High Risk and High Need Members

4.10.6.1 The MCO shall provide Care Management for Members identified as "high-risk"/"high-need" through the Comprehensive Assessment. Every high-risk/high-need Member identified as needing Care Management shall be assigned a designated Care Manager.

4.10.6.2 [Amendment #5:] Beginning January 1, 2021, Care Management for high-risk/high-need Members shall be conducted for at least three percent (3%) of the total Members. [Amendment #5:] For the period January 1, 2021 through June 30, 2021, Care Management for high-risk/high-need Members shall be conducted for at least three percent (3%) of the total Members by March 1, 2021.

4.10.6.2.1 [Amendment #6:] Beginning March 1, 2021, Care Management for shall be conducted for at least three percent (3%) of the total membership.

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~~[Amendment #1:] Care Management for high-risk/high-need Members shall be conducted for at least 15 percent (15%) of the total Members by March 1, 2020, or the MCO shall provide to DHHS documentation of how fewer Members were determined not to meet the MCO's Risk Stratification Criteria for being high-risk/high-need members in need of Care Management.~~

~~[Base Contract:] Care Management for high-risk/high-need Members shall be conducted for at least 15 percent (15%) of the total Members by January 1, 2020, or the MCO shall provide to DHHS documentation of how fewer Members were determined not to meet the MCO's Risk Stratification Criteria for being high-risk/high-need members in need of Care Management.~~

4.10.6.3 Members selected for Care Management shall be informed of:

4.10.6.3.1 The nature of the Care Management engagement relationship;

4.10.6.3.2 Circumstances under which information shall be disclosed to third parties, consistent with State and federal law;

4.10.6.3.3 The availability of a grievance and appeals process;

4.10.6.3.4 The rationale for implementing Care Management services; and

4.10.6.3.5 The processes for opting out of and terminating Care Management services.

4.10.6.4 The MCO's Care Management responsibilities shall include, at a minimum:

4.10.6.4.1 Coordination of physical, mental health, Substance Use Disorder and social services;

4.10.6.4.2 Quarterly medication reconciliation;

4.10.6.4.3 Monthly telephonic contact with the Member;

4.10.6.4.4 Monthly communication with the care team either in writing or telephonically for coordination and updating of the care plan for dissemination to care team participants;

4.10.6.4.5 Referral follow-up monthly;

4.10.6.4.6 Peer support;

4.10.6.4.7 Support for unmet resource needs;

4.10.6.4.8 Training on disease self-management, as relevant; and

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4.10.6.4.9 Transitional Care Management as defined in Section 4.10.9 (Transitional Care Management).

4.10.6.5 The MCO shall convene a local community based care team for each Member receiving Care Management where relevant, dependent on a Member's needs including, but not limited to, the Member, caretaker(s), PCP, behavioral health Provider(s), specialist(s), HCBS case managers, school personnel as needed, nutritionist(s), and/or pharmacist(s).

4.10.6.6 The care team shall be chosen by the Member whose composition best meets the unique care needs to be addressed and with whom the Member has already established relationships.

4.10.6.7 The MCO shall identify what information is to be shared and how that information is communicated among all of the care team participants concerned with a Member's care to achieve safer and more effective health care including how the Care Coordination program interfaces with the Member's PCP and/or specialist Providers and existing community resources and supports.

4.10.6.8 The MCO shall develop a care plan, within 30 calendar days of the completed Comprehensive Assessment, for each high-risk/high need Member identified through a Comprehensive Assessment who is in need of a course of treatment or regular Care Management monitoring. [42 CFR 438.208(c)(3)]

4.10.6.9 The MCO's care plan shall be regularly updated and incorporate input from the local community based care team participants and the Member. The care plan shall be comprehensively updated:

4.10.6.9.1 At least quarterly;

4.10.6.9.2 When a Member's circumstances or needs change significantly;

4.10.6.9.3 At the Member's request;

4.10.6.9.4 When a re-assessment occurs; and

4.10.6.9.5 Upon DHHS's request.

4.10.6.10 The care plan format shall be submitted to DHHS for review as part of the Readiness Review process and annually thereafter.

4.10.6.11 The MCO shall track the Member's progress through routine care team conferences, the frequency to be determined by the MCO based on the Member's level of need.

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4.10.6.12 The MCO shall develop policies and procedures that describe when Members should be discharged from the Care Management program, should the care team determine that the Member no longer requires a course of treatment which was episodic or no longer needs ongoing care monitoring.

4.10.6.13 Policies and procedures for discharge shall include a Member notification process.

4.10.6.14 For high-risk/high-needs Members who have been determined, through a Comprehensive Assessment, to need a course of treatment or regular care monitoring, the MCO shall ensure there is a mechanism in place to permit such Members to directly access a specialist as appropriate for the Member's condition and identified needs. [42 CFR 438.208(c)(4)]

4.10.6.15 The MCO shall ensure that each Provider furnishing services to Members maintains and shares a Member health record in accordance with professional standards. [42 CFR 438.208(b)(5)]

4.10.6.16 The MCO shall use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Member in accordance with confidentiality requirements in 45 CFR 160 and 164, this Agreement, and all other applicable laws and regulations. [42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164]

4.10.6.17 The MCO shall develop and implement a strategy to address how the Interoperability Standards Advisory standards, from the Office of the National Coordinator for Health Information Technology, informs the MCO system development and interoperability.

4.10.7 Care Managers

4.10.7.1 The MCO shall formally designate a Care Manager that is primarily responsible for coordinating services accessed by the Member.

4.10.7.2 The MCO shall provide to Members information on how to contact their designated Care Manager. [42 CFR 438.208(b)(1)]

4.10.7.3 [Amendment #2:] Care Managers, whether hired by the MCO or subcontracted through a Designated Local Care Management ~~Network-Entity~~, shall have the qualifications and competency in the following areas:

4.10.7.3.1 All aspects of person-centered needs assessments and care planning;

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- 4.10.7.3.2 Motivational interviewing and self-management;
- 4.10.7.3.3 Trauma-informed care;
- 4.10.7.3.4 Cultural and linguistic competency;
- 4.10.7.3.5 Understanding and addressing unmet resource needs including expertise in identifying, accessing and utilizing available social support and resources in the Member's community; and
- 4.10.7.3.6 Adverse childhood experiences and trauma.

4.10.7.4 Care Managers shall be trained in the following:

- 4.10.7.4.1 Disease self-management;
- 4.10.7.4.2 Person-centered needs assessment and care planning including coordination of care needs;
- 4.10.7.4.3 Integrated and coordinated physical and behavioral health;
- 4.10.7.4.4 Behavioral health crisis response (for Care Managers with assigned Members with behavioral health needs);
- 4.10.7.4.5 Cultural and linguistic competency;
- 4.10.7.4.6 Family support; and
- 4.10.7.4.7 Understanding and addressing unmet resource needs, including expertise in identifying and utilizing available social supports and resources in the Member's community.

4.10.7.5 Care Managers shall remain conflict-free which shall be defined as not being related by blood or marriage to a Member, financially responsible for a Member, or with any legal power to make financial or health related decisions for a Member.

4.10.8 Local Care Management

4.10.8.1 Local Care Management shall mean that the MCO shall provide real-time, high-touch, in-person Care Management and consistent follow up with Providers and Members to assure that selected Members are making progress with their care plans.

4.10.8.1.1 [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] [Amendment #5:] As described in this Section 4.10.8, Local Care Management is optional for the period January 1, 2021 through August 31, 2024 ~~June 30, 2023~~ 2024.

4.10.8.1.1.1. [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] For the period July

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1, 2021 through August 31, 2024 June 30 December 31, 2023, the term "Local Care Management" shall also mean "Care Management" in this Section 4.10.8.

4.10.8.1.2 ~~[Amendment #9] [Amendment #7] [Amendment #6:] Intentionally left blank. The MCO shall be eligible for credit to the withhold calculation described in the MCM Withhold and Incentive Program guidance when the MCO opts to participate in a Department approved Local Care Management Pilot during the period described in Section 4.10.8.1.1, and meets obligations of the Pilot as described in separate guidance. [Amendment #5:] The MCO shall be eligible for a one-half percent (.5%) credit to the withhold calculation described in the MCM Withhold and Incentive Program guidance when the MCO opts to participate in a Department approved Local Care Management Pilot during the period described in Section 4.10.8.1.1. Eligibility for the withhold credit requires the MCO's earnest participation and effort to successfully develop the Pilot as determined solely by DHHS and outlined in the MCM Withhold and Incentive Guidance.~~

4.10.8.1.2.1. ~~[Amendment #6:] For the Pilot timeframe January 1, 2021 through June 30, 2021, the MCO shall be eligible for one-half (.5%) percent credit to the withhold calculation as described in the MCM Withhold and Incentive Guidance.~~

4.10.8.1.2.2. [Amendment #7:] For the Pilot timeframe July 1, 2021 through December 31, 2021, the MCO shall be eligible for additional one-quarter (.25%) percent credits to the SFY 2021 withhold calculation for successful implementation of each of the four (4) subsequent phases of the Pilot up to a one percent (1%) withhold credit as determined at DHHS's sole discretion. [Amendment #6:] For the Pilot timeframe beginning July 1, 2021, the MCO shall be eligible for additional one-quarter (.25%) percent credits to the withhold calculation for successful implementation of each of the four (4) subsequent phases of the Pilot up to a one percent (1%) withhold credit as described in the MCM Withhold and Incentive Guidance to be developed over time.

4.10.8.1.2.3. [Amendment #6:] Eligibility for the withhold credit requires the MCO's earnest participation and effort to successfully develop the Pilot as determined solely by DHHS and outlined in the MCM Withhold and Incentive Guidance.

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4.10.8.1.3 ~~[Amendment #8:] [Amendment #7:] For the Pilot timeframe January 1, 2022 through June 30-December 31, 2022, the MCO shall be eligible for a SFY 2022 withhold calculation credit up to one-half percent (.5%) as described in the MCM Withhold and Incentive Guidance.~~

4.10.8.1.4 ~~[Amendment #9:] [Amendment #8] Intentionally left blank. The MCO shall be eligible for a SFY 2023 withhold capitation credit up to one half percent (.5%) based on Members who have completed their determinations between July 1, 2022 through December 31, 2022 as described in the MCM Withhold and Incentive Guidance.~~

4.10.8.2 The MCO shall design an effective Local Care Management structure for fifty percent (50%) of high-risk or high-need Members, including those who are medically and socially complex or high utilizers.

4.10.8.3 ~~[Amendment #5:]~~ The MCO shall ensure that the fifty percent (50%) requirement is met by ensuring access to Local Care Management in all regions of New Hampshire ~~by January 1, 2021;~~ the MCO shall be considered out of compliance should any one (1) region have less than twenty five percent (25%) of high-risk or high-need Members receiving Local Care Management, unless the MCO receives DHHS approval as part of the MCO's Local Care Management Plan (further described in this Section 4.10.8).

4.10.8.4 The MCO is encouraged to leverage Local Care Management by contracting with designated community-based agencies or Care Management entities, inclusive of IDNs that meet requirements, that shall assume responsibility for performing Care Coordination, Transitional Care Management, and/or Care Management functions for high risk and/or high-need Members.

4.10.8.4.1 ~~[Amendment #2:]~~ After good faith negotiations with a Local Care Management ~~Network Agency~~ should the MCO be unable to contract with the Local Care Management ~~Network Agency~~ for Care Coordination, Transitional Care Management, and/or Care management functions for high-risk/high-need Members, and continue to be unable to contract with any Local Care Management ~~Network Agency~~ after subsequent good faith negotiations with the assistance of DHHS, the MCO may submit to DHHS for a request for an exception to the requirement for compliance with the 50% Local Care Management standard. DHHS may approve or deny the request in its sole discretion.

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4.10.8.5 [Amendment #2:] The MCO, or its Designated Local Care Management ~~Network-Entity~~, shall designate Care Managers who shall provide in-person Care Management for Members either in the community setting, provider outpatient setting, hospital, or ED.

4.10.8.6 [Amendment #2:] The MCO shall ensure there is a clear delineation of roles and responsibilities between the MCO and Designated Local Care Management ~~Networks-Entities~~ that are responsible for Care Management in order to ensure no gaps or duplication in services.

4.10.8.7 The MCO or its designated Local Care Managers shall be embedded in one (1) outpatient service site, float between multiple outpatient sites, provide transition of care services from the hospital or ED setting, and provide home based Care Management.

4.10.8.8 [Amendment #2:] Designated Local Care Management ~~Networks-Entities~~ shall include:

4.10.8.8.1 [Amendment #2:] IDNs that have been certified as Local Care Management ~~Networks-Entities~~ by DHHS;

4.10.8.8.2 Health Homes, if DHHS elects to implement Health Homes under Medicaid State Plan Amendment authority;

4.10.8.8.3 Designated community-based agencies or Care Management entities, inclusive of IDNs that meet requirements and DHHS designated regional substance use disorder hubs or spokes, that shall assume responsibility for performing Care Coordination, Transitional Care Management, and/or Care Management functions for high risk and/or high-need Members;

4.10.8.8.4 Other contracted entities capable of performing Local Care Management for a designated cohort of Members, as identified by the MCO as part of its Local Care Management Plan (further described in this Section 4.10.8) and approved by DHHS;

4.10.8.8.5 [Amendment #2:] For the delegation to community-based agencies or Care Management entities ~~designated local care management entities~~ not certified by DHHS for medical utilization review services, the MCO shall seek, where required, licensing in accordance with any State or federal law, including but not limited to RSA 420-E, or additional NCQA accreditation.

4.10.8.9 DHHS shall evaluate whether IDNs are able to provide effective Local Care Management services to selected populations; if and when one (1) or more IDNs are certified, the MCO is required to

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directly contract with the certified IDN(s) for the delivery of Local Care Management services.

4.10.8.10 For any IDN that is not certified by DHHS, the MCO is not required to directly contract with the uncertified IDN for the delivery of Local Care Management services (either because the individual IDN was not certified and/or DHHS has not yet instituted its certification process).

4.10.8.10.1 In this instance the MCO shall enter into a memorandum of understanding with the non-certified IDN(s).

4.10.8.10.2 The memorandum of understanding shall identify roles and responsibilities with respect to Members served by the MCO and the IDN(s), and provide for the timely exchange of data between the MCO and the IDN(s) on such Members.

4.10.8.11 The MCO shall also work with IDNs to leverage regional access point services. The MCO is required to contract with and enter into a payment arrangement with qualified IDNs, providing for reimbursement on terms specified by DHHS in guidance unless otherwise approved by DHHS.

4.10.8.12 [Amendment #2:] Any Care Coordination and Care Management requirements that apply to the MCO shall also apply to the MCOs' Designated Local Care Management Networks-Entities.

4.10.8.13 [Amendment #5:] The MCO shall amend its Care Management Plan to describe its Local Care Management Plan by September 1, 2020, as prescribed by DHHS, and annually thereafter in accordance with Exhibit O ~~for prior approval by DHHS.~~ ~~[Amendment #2:] The MCO shall submit to DHHS its Local Care Management Plan in accordance with Exhibit O for prior approval by DHHS as part of the Readiness Review and annually thereafter.~~

4.10.8.14 [Amendment #2:] The Plan shall include the structure of the Local Care Management to be provided, the percentage (%) of high-risk/high-need Members who shall receive Local Care Management, the list of Designated Local Care Management Networks-Entities that shall conduct the Local Care Management, and a description of the geography and Priority Populations the Designated Local Care Management Networks-Entities shall serve.

4.10.8.15 The MCO shall report against their Local Care Management Plans in accordance with Exhibit O, including:

4.10.8.15.1 Volume of Care Management outreach attempts;

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4.10.8.15.2 Number of Members receiving Local Care Management by intensity of engagement;

4.10.8.15.3 Duration of sustained Local Care Management activities;

4.10.8.15.4 Number and percent (%) of Members receiving face-to-face Care Management; and

4.10.8.15.5 Type of staff conducting face-to-face Local Care Management

4.10.8.16 [Amendment #2:] Data Sharing with Local Care Management Networks-Entities

4.10.8.16.1 [Amendment #2:] Consistent with all applicable State and federal laws and regulations, and utilizing all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information and to facilitate the provision of services and Care Management as intended by this Agreement, the MCO shall provide identifiable Member-level data on a monthly basis to Local Care Management Networks-Entities, all community-based agencies or Care Management entities with which the MCO otherwise subcontracts for purposes of providing Care Management and care coordination to MCM Members, and IDNs regarding:

4.10.8.16.1.1. Each Member's diagnosis(es);

4.10.8.16.1.2. Utilization of services;

4.10.8.16.1.3. Total cost of care

4.10.8.16.1.4. Point of access to service.

4.10.8.16.2 [Amendment #8:] The MCO shall, as described in Section 4.10.9 (Transitional Care Management), demonstrate that it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real time or designated receiving facility in real time or near real time.

4.10.8.16.3 [Amendment #2:] The MCO shall ensure that ADT data from applicable hospitals be made available to Primary Care Providers, behavioral health Providers, Integrated Delivery Networks, Local Care Management Networks-Entities, community-based agencies, and all other Care Management entities within twelve (12) hours of the admission, discharge, or transfer.

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4.10.8.16.4 [Amendment #2:] The MCO shall, as directed by DHHS, and demonstrated during the readiness period, collaborate with the IDNs to utilize the event notification and shared care plan system employed by IDNs as applicable for exchanging Member information necessary to provide Care Management and Care Coordination services to Members served by an IDN and, as applicable, other Local Care Management Networks-Entities.

4.10.9 Transitional Care Management

4.10.9.1 [Amendment #8:] The MCO shall be responsible for managing transitions of care for all Members moving from one (1) clinical setting to another, including step-up or step-down treatment programs for Members in need of continued mental health and Substance Use Disorder services, to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes.

4.10.9.2 The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]

4.10.9.3 The MCO shall develop policies and procedures for DHHS review, as part of the Readiness Review process and annually thereafter, which describe how transitions of care between settings shall be effectively managed including data systems that trigger notification that a Member is in transition.

4.10.9.4 The MCO's transition of care policies shall be consistent with federal requirements that meet the State's transition of care requirements. [42 CFR 438.62(b)(1)-(2)]

4.10.9.5 The MCO shall have a documented process to, at a minimum:

4.10.9.5.1 Coordinate appropriate follow-up services from any inpatient or facility stay;

4.10.9.5.2 Support continuity of care for Members when they move from home to foster care placement; foster care to independent living; return from foster care placement to community; or change in legal status from foster care to adoption.

4.10.9.5.3 Schedule a face-to-face visit to complete a Comprehensive Assessment and update a Member's care plan when a Member is hospitalized;

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4.10.9.5.4 Evaluate Members for continued mental health and Substance Use Disorder services upon discharge from an inpatient psychiatric facility or residential treatment center as described in Section 4.11.5.18 (New Hampshire Hospital); and

4.10.9.5.5 Coordinate with inpatient discharge planners for Members referred for subacute treatment in a nursing facility.

4.10.9.6 The MCO shall have an established process to work with Providers (including hospitals regarding notice of admission and discharge) to ensure appropriate communication among Providers and between Providers and the MCO to ensure that Members receive appropriate follow-up care and are in the most integrated and cost-effective delivery setting appropriate for their needs.

4.10.9.7 The MCO shall implement a protocol to identify Members who use ED services inappropriately, analyze reasons why each Member did so and provide additional services to assist the Member to access appropriate levels of care including assistance with scheduling and attending follow-up care with PCPs and/or appropriate specialists to improve Continuity of Care, resolve Provider access issues, and establish a medical home.

4.10.9.8 The MCO shall demonstrate, at a minimum, that it has active access to ADT data source(s) that correctly identifies when empaneled Members are admitted, discharged, or transferred to/from an ED or hospital in real time or near real time.

4.10.9.9 [Amendment #2:] The MCO shall ensure that ADT data from applicable hospitals be made available to Primary Care Providers, behavioral health Providers, Integrated Delivery Networks, Local Care Management Networks—~~Entities~~, and all other Care Management Entities within twelve (12) hours of the admission, discharge, or transfer.

4.10.9.10 The MCO shall ensure that Transitional Care Management includes, at a minimum:

4.10.9.10.1 Care Management or other services to ensure the Member's care plan continues;

4.10.9.10.2 Facilitating clinical hand-offs;

4.10.9.10.3 Obtaining a copy of the discharge plan/summary prior to the day of discharge, if available, otherwise, as soon as it is available, and documenting that a follow-up outpatient visit is scheduled, ideally before discharge;

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4.10.9.10.4 Communicating with the Member's PCP about discharge plans and any changes to the care plan;

4.10.9.10.5 Conducting medication reconciliation within forty-eight (48) business hours of discharge;

4.10.9.10.6 Ensuring that a Care Manager is assigned to manage the transition;

4.10.9.10.7 Follow-up by the assigned Care Manager within forty-eight (48) business hours of discharge of the Member;

4.10.9.10.8 Determining when a follow up visit should be conducted in a Member's home

4.10.9.10.9 Supporting Members to keep outpatient appointments; and

4.10.9.10.10 A process to assist with supporting continuity of care for the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care who become enrolled in the plan, including prospective enrollment so that any care required prior to effective date of enrollment is covered.

4.10.9.11 The MCO shall assist with coordination between the children and adolescent service delivery system as these Members transition into the adult mental health service delivery system, through activities such as communicating treatment plans and exchange of information.

4.10.9.12 The MCO shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge:

4.10.9.12.1 The outpatient Provider shall be involved in the admissions process when possible; if the outpatient Provider is not involved, the outpatient Provider shall be notified promptly of the Member's hospital admission;

4.10.9.12.2 Psychiatric hospital and residential treatment facility discharges shall not occur without a discharge plan (i.e. an outpatient visit shall be scheduled before discharge to ensure access to proper Provider/medication follow-up; and an appropriate placement or housing site shall be secured prior to discharge);

4.10.9.12.3 The hospital's evaluation shall be performed prior to discharge to determine what, if any, mental health or Substance Use Disorder services are Medically Necessary. Once deemed Medically

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Necessary, the outpatient Provider shall be involved in the discharge planning, the evaluation shall include an assessment for any social services needs such as housing and other necessary supports the young adults need to assist in their stability in their community; and

4.10.9.12.4 A procedure to ensure Continuity of Care regarding medication shall be developed and implemented.

4.10.10 Coordination and Integration with Social Services and Community Care

4.10.10.1 The MCO shall implement procedures to coordinate services the MCO furnishes to Members with the services the Member receives from community and social service Providers. [42 CFR 438.208(b)(2)(iv)]

4.10.10.2 The MCO shall utilize 2-1-1 NH, which is New Hampshire's statewide, comprehensive, information and referral service. The MCO shall leverage and partner with 2-1-1 NH to ensure warm transfers and the ability to report on closed loop referrals.

4.10.10.3 The MCO's Care Management shall include help for Members in addressing unmet resource needs through strategies including, at a minimum:

4.10.10.3.1 How the MCO identifies available community support services and facilitates referrals to those entities for Members with identified needs;

4.10.10.3.2 Providing in-person assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications;

4.10.10.3.3 Having a housing specialist on staff or on contract who can assist Members who are homeless in securing housing; and

4.10.10.3.4 Providing access to medical-legal partnership for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance Providers.

4.10.10.4 In addressing unmet resource needs for Members, the MCO shall promote access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support. The MCO shall establish Care Management competencies, as outlined below:

4.10.10.4.1 Health Risk Assessment Screening, Claims Analysis, and/or Member or Provider Referral: the MCO ensure that a care needs screening, including social determinants of health questions, is conducted.

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4.10.10.4.2 Risk Scoring and Stratification by Member Level of Need: The MCO shall identify Priority Populations for further review and likely receipt of intensive Care Management services. With respect to social determinants, the MCO, at minimum, shall ensure that Priority Populations are inclusive of homeless Members, Members facing multiple barriers to food, housing and transportation.

4.10.10.4.3 High Risk/High-Need Members: The MCO shall ensure that a more in-depth assessment is conducted to confirm the need for Care Management services and begin to develop a care plan. As with the screening, the in-depth assessment shall include questions regarding social determinants of health.

4.10.10.4.4 The MCO shall provide/arrange for Care Management services that take into account social determinants of health. At minimum, these services shall include in-person assistance connecting with social services that can improve health, including a housing specialist familiar with options in the community.

4.10.10.5 For Members who do not require such intensive services, the MCO shall provide guidance/navigational coordination, which includes:

4.10.10.5.1 Ensuring that each Member has an ongoing source of care and health services appropriate for his or her needs;

4.10.10.5.2 Coordinating services provided by community and social support Providers;

4.10.10.5.3 Linking Members to community resources and social supports; and

4.10.10.5.4 Reporting on closed loop referrals or the overall effectiveness of the types of social determinant-related Care Coordination services, in accordance with Exhibit O.

4.10.10.6 The MCO shall develop relationships that actively link Members with other State, local, and community programs that may provide or assist with related health and social services to Members including, but not limited to:

4.10.10.6.1 Juvenile Justice and Adult Community Corrections;

4.10.10.6.2 Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.;

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4.10.10.6.3 Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations;

4.10.10.6.4 Public Health Agencies;

4.10.10.6.5 Schools;

4.10.10.6.6 The court system;

4.10.10.6.7 ServiceLink Resource Network;

4.10.10.6.8 2-1-1 NH;

4.10.10.6.9 Housing; and

4.10.10.6.10 VA Hospital and other programs and agencies serving service Members, veterans and their families.

4.10.10.7 The MCO shall report on the number of referrals for social services and community care provided to Members by Member type, consistent with the format and content requirements in accordance with Exhibit O.

4.11 Behavioral Health

4.11.1 General Coordination Requirements

4.11.1.1 This section describes the delivery and coordination of Behavioral Health Services and supports, for both mental health and Substance Use Disorder, delivered to children, youth and transition-aged youth/young adults, and adults.

4.11.1.2 The MCO shall deliver services in a manner that is both clinically and developmentally appropriate and that considers the Members, parents, caregivers and other networks of support the Member may rely upon.

4.11.1.3 The delivery of service shall be Member-centered and align with the principles of system of care and Recovery and resiliency.

4.11.1.4 The MCO shall provide Behavioral Health Services in accordance with this Agreement and all applicable State and federal laws and regulations.

4.11.1.5 The MCO shall be responsible for providing a full continuum of physical health and Behavioral Health Services; ensuring continuity and coordination between covered physical health and Behavioral Health Services; and requiring collaboration between physical health and behavioral health Providers.

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4.11.1.6 Consistent with He-M 425, the MCO shall be required to enter into a capitation model of contracting with CMH Programs and CMH Providers, which is essential to supporting the State's Delivery System Reform Incentive Payment Program (DSRIP) waiver and furthering physical and behavioral health integration in the MCM program.

4.11.1.7 The MCO shall comply with key administrative functions and processes, which may include, but are not limited to:

4.11.1.7.1 Processing timely prospective payment from a Member eligibility list provided by the CMH Program/CMH Provider;

4.11.1.7.2 Determining whether Members are eligible for the DHHS-required Capitation Payments, or should be paid on a FFS basis to the CMH Program/CMH Provider;

4.11.1.7.3 Providing detailed MCO data submissions to DHHS and the CMH Program or CMH Provider for purposes of reconciling payments and performance (e.g., 835 file);

4.11.1.7.4 Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs/CMH Providers (by region); and

4.11.1.7.5 All additional capabilities set forth by DHHS during the Readiness Review process.

4.11.1.8 Behavioral Health Subcontracts

4.11.1.8.1 If the MCO enters into a Subcontractor relationship with a behavioral health (mental health or Substance Use Disorder) Subcontractor to provide or manage Behavioral Health Services, the MCO shall provide a copy of the agreement between the MCO and the Subcontractor to DHHS for review and approval, including but not limited to any agreements with CMH Programs and CMH Providers as required in Section 4.11.5.1 (Contracting for Community Mental Health Services).

4.11.1.8.2 Such subcontracts shall address the coordination of services provided to Members by the Subcontractor, as well as the approach to Prior Authorization, claims payment, claims resolution, contract disputes, performance metrics, quality health outcomes, performance incentives, and reporting.

4.11.1.8.3 The MCO remains responsible for ensuring that all requirements of this Agreement are met, including requirements to ensure continuity and coordination between physical health and Behavioral Health Services, and that any Subcontractor adheres to

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all requirements and guidelines, as outlined in Section 3.14 (Subcontractors).

4.11.1.9 Promotion of Integrated Care

4.11.1.9.1 The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible.

4.11.1.9.2 In accordance with Exhibit O, the MCO shall include in its Behavioral Health Strategy Plan and Report efforts towards continued progression of the SAMHSA Integration Framework at all contracted primary and behavioral health Providers.

4.11.1.10 Approach to Behavioral Health Services

4.11.1.10.1 The MCO shall ensure that its clinical standard and operating procedures are consistent with trauma-informed models of care, as defined by SAMHSA²² and reflect a focus on Recovery and resiliency.²³

4.11.1.10.2 The MCO shall offer training inclusive of mental health first aid training, to MCO staff who manage the behavioral health contract and Participating Providers, including Care Managers, physical health Providers, and Providers on Recovery and resiliency, Trauma-Informed Care, and Community Mental Health Services and resources available within the applicable region(s).

4.11.1.10.3 The MCO shall track training rates and monitor usage of Recovery and resiliency and Trauma-Informed Care practices.

4.11.1.10.4 In accordance with Section 4.8.2 (Practice Guidelines and Standards), the MCO shall ensure that Providers, including those who do not serve behavioral health Members, are trained in Trauma-Informed models of Care.

4.11.1.11 Behavioral Health Strategy Plan and Report

4.11.1.11.1 The MCO shall submit to DHHS an initial plan describing its program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health

²² Substance Abuse and Mental Health Services Administration, "Trauma-Informed Approach and Trauma-Specific Interventions," available at <https://www.samhsa.gov/nctic/trauma-interventions>

²³ Substance Abuse and Mental Health Services Administration, "Recovery and Recovery Support," available at <https://www.samhsa.gov/recovery>

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Providers. In accordance with Exhibit O, the initial Plan shall address but not be limited to how the MCO shall:

4.11.1.11.1.1. Assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare;

4.11.1.11.1.2. Assure the appropriateness of the diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs;

4.11.1.11.1.3. Assure the promotion of Integrated Care;

4.11.1.11.1.4. Reduce Psychiatric Boarding described in Section 4.11.5.17 (Reducing Psychiatric Boarding);

4.11.1.11.1.5. Reduce Behavioral Health Readmissions described in Section 4.11.5.18.4 (Reduction in Behavioral Health Readmissions);

4.11.1.11.1.6. Support the NH 10-Year Plan outlined in Section 4.11.5.15 (Implementation of New Hampshire's 10-Year Mental Health Plan);

4.11.1.11.1.7. Assure the appropriateness of psychopharmacological medication;

4.11.1.11.1.8. Assure access to appropriate services;

4.11.1.11.1.9. Implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and

4.11.1.11.1.10. Other information in accordance with Exhibit O.

4.11.1.11.2 On an annual basis and in accordance with Exhibit O, the MCO shall provide an updated Behavioral Health Strategy Plan and Report which shall include an effectiveness analysis of the initial Plan's program, policies and procedures.

4.11.1.11.2.1. The analysis shall include MCO interventions which require improvement, including improvements in SAMHSA Standard Framework for Levels of Integrated Healthcare, continuity, coordination, and collaboration for physical health and Behavioral Health Services.

4.11.1.12 Collaboration with DHHS

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4.11.1.12.1 At the discretion of DHHS, the MCO shall provide mental health and Substance Use Disorder updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.1.12.2 To improve health outcomes for Members and ensure that delivery of services are provided at the appropriate intensity and duration, the MCO shall meet with behavioral health programs and DHHS at least four (4) times per year to discuss quality assurance activities conducted by the MCO, such as PIPs and APMs, and to review quality improvement plans and outstanding needs.

4.11.1.12.3 Quarterly meetings shall also include a review of progress against deliverables, improvement measures, and select data reports as detailed in Exhibit O. Progress and data reports shall be produced and exchanged between the MCO and DHHS two (2) weeks prior to each quarterly meeting.

4.11.1.12.4 At each meeting, the MCO shall update DHHS on the following topics:

4.11.1.12.4.1. Updates related to the MCO's Behavioral Health Strategy Report and interventions to improve outcomes;

4.11.1.12.4.2. [Amendment #5:] Intentionally left blank
~~Results of the MCO's quarterly crisis line;~~

4.11.1.12.4.3. Utilization of ACT services and any waitlists for ACT services;

4.11.1.12.4.4. Current EBSE rates;

4.11.1.12.4.5. Current compliance with New Hampshire Hospital discharge performance standards;

4.11.1.12.4.6. Current compliance with ED discharge performance standards for overdoses and Substance Use Disorder;

4.11.1.12.4.7. Updates regarding services identified in Section 4.11 (Behavioral Health);

4.11.1.12.4.8. Updates on Mental Health and Substance Use Disorder PIPs; and

4.11.1.12.4.9. Other topics requested by DHHS.

4.11.1.12.5 For all Members, the MCO shall work in collaboration with DHHS and the NH Suicide Prevention Council to promote

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suicide prevention awareness programs, including the Zero Suicide program.

4.11.1.12.6 The MCO shall submit to DHHS, as specified by DHHS in Exhibit O, its implementation plan for incorporating the "Zero Suicide" program into its operations; the plan shall include, in addition to any other requirements specified in Exhibit O related to the plan, how the MCO shall:

4.11.1.12.6.1. Incorporate efforts to implement standardized provider screenings and other preventative measures; and

4.11.1.12.6.2. Incorporate the Zero Suicide Consensus Guide for Emergency Departments, as described in Section 4.8.2 (Practice Guidelines and Standards).

4.11.1.13 Primary Care Provider Screening for Behavioral Health Needs

4.11.1.13.1 The MCO shall ensure that the need for Behavioral Health Services is systematically identified by and addressed by the Member's PCP at the earliest possible time following initial enrollment of the Member and ongoing thereafter or after the onset of a condition requiring mental health and/or Substance Use Disorder treatment.

4.11.1.13.2 At a minimum, this requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to behavioral health Providers if clinically necessary.

4.11.1.13.3 The MCO shall encourage PCPs and other Providers to use a screening tool approved by DHHS, as well as other mechanisms to facilitate early identification of behavioral health needs.

4.11.1.13.4 The MCO shall require all PCPs and behavioral health Providers to incorporate the following domains into their screening and assessment process:

4.11.1.13.4.1. Demographic,

4.11.1.13.4.2. Medical,

4.11.1.13.4.3. Substance Use Disorder,

4.11.1.13.4.4. Housing,

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- 4.11.1.13.4.5. Family & support services,
- 4.11.1.13.4.6. Education,
- 4.11.1.13.4.7. Employment and entitlement,
- 4.11.1.13.4.8. Legal, and
- 4.11.1.13.4.9. Risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

4.11.1.13.5 The MCO shall require that pediatric Providers ensure that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

- 4.11.1.13.5.1. Depression screening (e.g., PHQ 2 & 9); and
- 4.11.1.13.5.2. Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

4.11.1.14 Referrals

4.11.1.14.1 The MCO shall ensure through its Health Risk Assessment Screening (described in Section 4.10.2) and its Risk Scoring and Stratification methodology that Members with a potential need for Behavioral Health Services, particularly Priority Population Members as described in Section 4.10.3 (Priority Populations), are appropriately and timely referred to behavioral health Providers if co-located care is not available.

4.11.1.14.2 This shall include education about Behavioral Health Services, including the Recovery process, Trauma-Informed Care, resiliency, CMH Programs/CMH Providers and Substance Use Disorder treatment Providers in the applicable region(s).

4.11.1.14.3 The MCO shall develop a referral process to be used by Participating Providers, including what information shall be exchanged and when to share this information, as well as notification to the Member's Care Manager.

4.11.1.14.4 The MCO shall develop and provide Provider education and training materials to ensure that physical health providers know

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when and how to refer Members who need specialty Behavioral Health Services.

4.11.1.14.5 The MCO shall ensure that Members with both physical health and behavioral health needs are appropriately and timely referred to their PCPs for treatment of their physical health needs when Integrated Care is not available.

4.11.1.14.6 The MCO shall develop a referral process to be used by its Providers. The referral process shall include providing a copy of the physical health consultation and results to the behavioral health Provider.

4.11.1.14.7 The MCO shall develop and provide Provider education and training materials to ensure that behavioral health Providers know when and how to refer Members who need physical health services.

4.11.1.15 Prior Authorization

4.11.1.15.1 As of September, 2017, the MCO shall comply with the Prior Authorization requirements of House Bill 517 for behavioral health drugs, including use of the universal online Prior Authorization form provided by DHHS for drugs used to treat mental illness.

4.11.1.15.2 The MCO shall ensure that any Subcontractor, including any CMH Program/CMH Provider, complies with all requirements included in the bill.

4.11.1.16 Comprehensive Assessment and Care Plans for Behavioral Health Needs

4.11.1.16.1 The MCO's policies and procedures shall identify the role of physical health and behavioral health Providers in assessing a Member's behavioral health needs as part of the Comprehensive Assessment and developing a care plan.

4.11.1.16.2 For Members with chronic physical conditions that require ongoing treatment who also have behavioral health needs and who are not already treated by an integrated Provider team, the MCO shall ensure participation of the Member's physical health Provider (PCP or specialist), behavioral health Provider, and, if applicable, Care Manager, in the Comprehensive Assessment and care plan development process as well as the ongoing provision of services.

4.11.1.17 Written Consent

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4.11.1.17.1 Per 42 CFR Part 2 and NH Code of Administrative Rules, Chapter He-M 309, the MCO shall ensure that both the PCP and behavioral health Provider request written consent from Members to release information to coordinate care regarding mental health services or Substance Use Disorder services, or both; and primary care.

4.11.1.17.2 The MCO shall conduct a review of a sample of case files where written consent was required to determine if a release of information was included in the file.

4.11.1.17.3 The MCO shall report instances in which consent was not given, and, if possible, the reason why, and submit this report in accordance with Exhibit O.

4.11.1.18 Coordination Among Behavioral Health Providers

4.11.1.18.1 The MCO shall support communication and coordination between mental health and Substance Use Disorder service Providers and PCPs by providing access to data and information when the Member consent has been documented in accordance with State and federal law, including:

4.11.1.18.1.1. Assignment of a responsible party to ensure communication and coordination occur and that Providers understand their role to effectively coordinate and improve health outcomes;

4.11.1.18.1.2. Determination of the method of mental health screening to be completed by Substance Use Disorder service Providers;

4.11.1.18.1.3. Determination of the method of Substance Use Disorder screening to be completed by mental health service Providers;

4.11.1.18.1.4. Description of how treatment plans shall be coordinated among Behavioral Health Service Providers; and

4.11.1.18.1.5. Assessment of cross training of behavioral health Providers (i.e. mental health Providers being trained on Substance Use Disorder issues and Substance Use Disorder Providers being trained on mental health issues).

4.11.1.19 Member Service Line

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4.11.1.19.1 As further outlined in Section 4.4.4.3 (Member Call Center), the MCO shall operate a Member Services toll-free phone line that is used by all Members, regardless of whether they are calling about physical health or Behavioral Health Services.

4.11.1.19.2 The MCO shall not have a separate number for Members to call regarding Behavioral Health Services, but may either route the call to another entity or conduct a transfer to another entity after identifying and speaking with another individual at the receiving entity to accept the call (i.e., a "warm transfer").

4.11.1.19.3 If the MCO's nurse triage/nurse advice line is separate from its Member Services line, the nurse triage/nurse advice line shall be the same for all Members, regardless of whether they are calling about physical health and/or behavioral health term services.

4.11.1.20 Provision of Services Required by Courts

4.11.1.20.1 The MCO shall pay for all NH Medicaid State Plan services, to include assessment and diagnostic evaluations, for its Members as ordered by any court within the State. Court ordered treatment services shall be delivered at an appropriate level of care.

4.11.1.21 Sentinel Event Review

4.11.1.21.1 The MCO shall participate in sentinel event reviews conducted in accordance with the DHHS policy as requested by DHHS.

4.11.1.22 Behavioral Health Member Experience of Care Survey

4.11.1.22.1 The MCO shall contract with a third party to conduct a Member behavioral health experience of care survey on an annual basis.

4.11.1.22.2 The survey shall be designed by DHHS and the MCO's results shall be reported in accordance with Exhibit O. The survey shall comply with necessary NCQA Health Plan Accreditation standards.

4.11.2 Emergency Services

4.11.2.1 ~~[Amendment #5] Intentionally left blank. The MCO shall ensure, through its contracts with local Providers, that statewide crisis lines and Emergency Services are in place twenty four (24) hours a day, seven (7) days a week for Members experiencing a mental health or Substance Use Disorder crisis.~~

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4.11.2.2 The MCO shall ensure that all types of behavioral health crisis response services are included, such as mobile crisis and office-based crisis services.

4.11.2.2.1 ~~[Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #7:] For the period July 1, 2021 through August 31, 2024 June 30, 2023 June 30, December 30, 2022, certain mobile crisis services shall be carved-out of the at-risk services under the MCM benefit package as described in separate guidance.~~

4.11.2.3 Emergency Services shall be accessible to Members anywhere in the region served by the CMH Program/Provider.

4.11.2.4 ~~[Amendment #5] Described in Section 3.15.2 (Other MCO Required Staff), and pursuant to administrative rule, these crisis lines and Emergency Services teams shall employ clinicians and certified Peer Support Specialists.~~

4.11.2.5 ~~[Amendment #5] Intentionally left blank. The MCO shall be able to demonstrate during the Readiness Review process that its crisis line can effectively link Members to Emergency Services or other behavioral health crisis services and supports.~~

4.11.2.6 As directed by DHHS, and at the MCO's sole expense, the MCO shall contract with DHHS specified crisis service teams for both adults and children to meet these requirements.

4.11.2.7 At the discretion of DHHS, the MCO shall provide updates as requested by DHHS during regular Behavioral Health meetings between the MCO and DHHS on innovative and cost-effective models of providing mental health crisis and emergency response services that provide the maximum clinical benefit to the Member while also meeting DHHS's objectives to reduce admissions and increase community tenure.

4.11.2.8 ~~[Amendment #5] Intentionally left blank. In accordance with Exhibit O, the MCO shall submit quarterly crisis line data that lists the total calls received by the statewide crisis line attributable to Members, including the ultimate disposition of the call (e.g., educational, referral to care, no referral to care, etc.).~~

4.11.3 Behavioral Health Training Plan

4.11.3.1 In accordance with Exhibit O, the MCO shall develop a behavioral health training plan each year outlining how it will strengthen behavioral health capacity for Members within the state and support the efforts of CMH Programs/Providers to hire, retain and train qualified staff.

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4.11.3.2 The MCO shall coordinate with DHHS to reduce duplication of training efforts and submit the training plan to DHHS prior to program start and annually thereafter, inclusive of the training schedule and target Provider audiences.

4.11.3.3 As part of the training plan, the MCO shall promote Provider competence and opportunities for skill-enhancement through training opportunities and consultation, either through the MCO or other consultants with expertise in the area focused on through the training.

4.11.3.4 The MCO training plan shall include at least twenty-four (24) hours of training designed to sustain and expand the use of the:

4.11.3.4.1 Trauma Focused Cognitive Behavioral Therapy;

4.11.3.4.2 Trauma Informed Care;

4.11.3.4.3 Motivational Interviewing;

4.11.3.4.4 Interventions for Nicotine Education and Treatment;

4.11.3.4.5 Dialectical Behavioral Therapy (DBT);

4.11.3.4.6 Cognitive Behavioral Therapy;

4.11.3.4.7 Client Centered Treatment Planning;

4.11.3.4.8 Family Psychoeducation;

4.11.3.4.9 Crisis Intervention;

4.11.3.4.10 SBIRT for PCPs;

4.11.3.4.11 Depression Screening for PCPs;

4.11.3.4.12 Managing Cardiovascular and Metabolic Risk for People with SMI; and

4.11.3.4.13 MAT (including education on securing a SAMHSA waiver to provide MAT and, for Providers that already have such waivers, the steps required to increase the number of waiver slots).

4.11.3.5 The Training Plan shall also outline the MCO's plan to develop and administer the following behavioral health trainings for all Providers in all settings that are involved in the delivery of Behavioral Health Services to Members:

4.11.3.5.1 Training for primary care clinics on best practices for behavioral health screening and Integrated Care for common depression, anxiety and Substance Use Disorders;

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4.11.3.5.2 Training to physical health Providers on how and when to refer Members for Behavioral Health Services;

4.11.3.5.3 Training to behavioral health Providers on how and when to refer Members for physical health services;

4.11.3.5.4 Cross training to ensure that mental health Providers receive Substance Use Disorder training and Substance Use Disorder Providers receive mental health training;

4.11.3.5.5 New models for behavioral health interventions that can be implemented in primary care settings;

4.11.3.5.6 Clinical care integration models to Participating Providers; and

4.11.3.5.7 Community-based resources to address social determinants of health.

4.11.3.6 The MCO shall offer a minimum of two (2) hours of training each Agreement year to all contracted CMH Program/Provider staff on suicide risk assessment, suicide prevention and post intervention strategies in keeping with the DHHS's objective of reducing the number of suicides in NH.

4.11.3.7 The MCO shall provide, on at least an annual basis, training on appropriate billing practices to Participating Providers. DHHS reserves the discretion to change training plan areas of focus in accordance with programmatic changes and objectives.

4.11.3.8 In accordance with Exhibit O, the MCO shall summarize in the annual Behavioral Health Strategy Plan and Report the training that was provided, a copy of the agenda for each training, a participant registration list, and a summary, for each training provided, of the evaluations done by program participants, and the proposed training for the next fiscal year.

4.11.4 Parity

4.11.4.1 The MCO and its Subcontractors shall comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438, subpart K, which prohibits discrimination in the delivery of mental health and Substance Use Disorder services and in the treatment of Members with, at risk for, or recovering from a mental health or Substance Use Disorder.

4.11.4.2 Semi-Annual Report on Parity

4.11.4.2.1 The MCO shall complete the DHHS Parity Compliance Report which shall include, at a minimum:

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4.11.4.2.1.1. All Non-Quantitative and Quantitative Treatment Limits identified by the MCO pursuant to DHHS criteria;

4.11.4.2.1.2. All Member grievances and appeals regarding a parity violation and resolutions;

4.11.4.2.1.3. The processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for mental health or Substance Use Disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for medical/surgical benefits in the same classification;

4.11.4.2.1.4. A comparison of payment for services that ensure comparable access for people with mental health diagnoses; and

4.11.4.2.1.5. Any other requirements identified in Exhibit O. [61 Fed. Reg. 18413, 18414 and 18417 (March 30, 2016)]

4.11.4.2.2 The MCO shall review its administrative and other practices, including those of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance issued by State and federal entities.

4.11.4.2.3 The MCO shall annually submit a certification signed by the CEO and chief medical officer (CMO) stating that the MCO has completed a comprehensive review of the administrative, clinical, and utilization practices of the MCO for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and federal Mental Health Parity Law and any guidance issued by State and federal entities.

4.11.4.2.4 If the MCO determines that any administrative, clinical, or utilization practices were not in compliance with relevant requirements of the federal Mental Health Parity Law or guidance issued by State and federal entities during the calendar year, the certification shall state that not all practices were in compliance with federal Mental Health Parity Law or any guidance issued by state or federal entities and shall include a list of the practices not in

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compliance and the steps the MCO has taken to bring these practices into compliance.

4.11.4.2.5 A Member enrolled in any MCO may file a complaint with DHHS at nhparity@dhhs.nh.gov if services are provided in a way that is not consistent with applicable federal Mental Health Parity laws, regulations or federal guidance.

4.11.4.2.6 As described in Section 4.4 (Member Services), the MCO shall describe the parity compliant process, including the appropriate contact information, in the Member Handbook.

4.11.4.3 Prohibition on Lifetime or Annual Dollar Limits

4.11.4.3.1 The MCO shall not impose aggregate lifetime or annual dollar limits on mental health or Substance Use Disorder benefits. [42 CFR 438.905(b)]

4.11.4.4 Restrictions on Treatment Limitations

4.11.4.4.1 The MCO shall not apply any financial requirement or treatment limitation applicable to mental health or Substance Use Disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and the MCO shall not impose any separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits. [42 CFR 438.910(b)(1)]

4.11.4.4.2 The MCO shall not apply any cumulative financial requirements for mental health or Substance Use Disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. [42 CFR 438.910(c)(3)]

4.11.4.4.3 If an MCO Member is provided mental health or Substance Use Disorder benefits in any classification of benefit, the MCO shall provide mental health or Substance Use Disorder benefits to Members in every classification in which medical/surgical benefits are provided. [42 CFR 438.910(b)(2)]

4.11.4.4.4 The MCO shall not impose Non-Quantitative Treatment Limits for mental health or Substance Use Disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the Non-Quantitative Treatment Limits to mental health or Substance Use Disorder benefits in the classification are comparable to, and are applied no

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more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [42 CFR 438.910(d)]

4.11.4.5 Medical Necessity Determination

4.11.4.5.1 The MCO shall provide the criteria for medical necessity determinations for mental health or Substance Use Disorder benefits to any Member, potential Member, or Participating Provider upon request and at no cost.

4.11.5 Mental Health

4.11.5.1 Contracting for Community Mental Health Services

4.11.5.1.1 The MCO shall contract with CMH Programs and CMH Providers for the provision of Community Mental Health Services described in NH Code of Administrative Rules, Chapter He-M 426 on behalf of Medicaid Members who qualify for such services in accordance with He-M 401.24

4.11.5.1.2 The MCO's contract shall provide for monitoring of CMH Program/CMH Provider performance through quality metrics and oversight procedures of the CMH Program/CMH Provider.

4.11.5.1.3 The contract shall be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.14.2 (Contracts with Subcontractors). The contract shall, at minimum, address:

4.11.5.1.3.1. The scope of services to be covered;

4.11.5.1.3.2. Compliance with the requirements of this Agreement and all applicable State and federal laws, rules and regulations;

4.11.5.1.3.3. The role of the MCO versus the CMH Program/CMH Provider;

4.11.5.1.3.4. Procedures for communication and coordination between the MCO and the CMH Program/CMH Provider, other Providers serving the same Member and DHHS;

4.11.5.1.3.5. Data sharing on Members;

4.11.5.1.3.6. Data reporting between the CMH Program/CMH Provider and the MCO and DHHS; and

²⁴ Available at http://www.qencourt.state.nh.us/rules/About_Rules/listagencies.htm

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4.11.5.1.3.7. Oversight, enforcement, and remedies for contract disputes.

4.11.5.2 Payment to Community Mental Health Programs and Community Mental Health Providers

4.11.5.2.1 The MCO is required to enter into a capitated payment arrangement with CMH Programs to deliver Community Mental Health Services, providing for reimbursement on terms specified by DHHS in guidance.

4.11.5.2.2 The MCO shall reach agreements and enter into contracts with all CMH Programs that meet the terms specified by DHHS no later than ninety (90) calendar days after Agreement execution.

4.11.5.2.2.1. [Amendment #1:] For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in March 2019.
~~[Base Contract:] For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in January 2019.~~

4.11.5.2.3 [Amendment #5:] The MCO shall be subject to payment requirements described in Section 4.15.5 (Provider Payments; Community Mental Health Programs).

4.11.5.3 Provision of Community Mental Health Services

4.11.5.3.1 The MCO shall ensure that Community Mental Health Services are provided in accordance with the Medicaid State Plan and He-M 401.02, He-M 403.02 and He-M 426.

4.11.5.3.2 This includes, but is not limited, to ensuring that the full range of Community Mental Health Services are appropriately provided to eligible Members.

4.11.5.3.3 Eligible Members shall receive an individualized service plan created and updated regularly, consistent with State and federal requirements, including but not limited to He-M 401.

4.11.5.3.4 Eligible Members shall be offered the provisions of supports for illness self-management and Recovery;

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4.11.5.3.5 Eligible Members shall be provided with coordinated care when entering and leaving a designated receiving facility.

4.11.5.3.6 The MCO shall ensure that all Providers providing Community Mental Health Services comply with the requirements of He-M 426.

4.11.5.3.7 As described in He-M 400, a Member may be deemed eligible for Community Mental Health Services if the Member has a:

4.11.5.3.7.1. Severe or persistent mental illness (SPMI) for an adult;

4.11.5.3.7.2. SMI for an adult;

4.11.5.3.7.3. SPMI or SMI with low service utilization for an adult;

4.11.5.3.7.4. SED for a child; or

4.11.5.3.7.5. SED and interagency involvement for a child.

4.11.5.3.8 Any MCO quality monitoring or audits of the performance of the CMH Programs/CMH Providers shall be available to DHHS upon request.

4.11.5.3.9 To improve health outcomes for Members and ensure that the delivery of services is provided at the appropriate intensity and duration, the MCO shall meet with CMH Programs/CMH Providers and DHHS at least quarterly to coordinate data collection and ensure data sharing.

4.11.5.3.10 At a minimum, this shall include sharing of quality assurance activities conducted by the MCO and DHHS and a review of quality improvement plans, data reports, Care Coordination activities, and outstanding needs. Reports shall be provided in advance of quarterly meetings.

4.11.5.3.11 The MCO shall work in collaboration with DHHS, CMH Programs/CMH Providers to support and sustain evidenced-based practices that have a profound impact on Providers and Member outcomes.

4.11.5.4 Comprehensive Assessment and Care Plans

4.11.5.4.1 The MCO shall ensure, through its regular quality improvement activities, on-site reviews for children and youth, and reviews of DHHS administered quality service reviews for adults, that Community Mental Health Services are delivered in the least

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restrictive community based environment possible and based on a person-centered approach where the Member and his or her family's personal goals and needs are considered central in the development of the individualized service plans.

4.11.5.4.2 The MCO shall ensure that initial and updated care plans are based on a Comprehensive Assessment conducted using an evidenced-based assessment tool, such as the NH version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

4.11.5.4.3 If the MCO or a CMH Program/CMH Provider acting on behalf of the MCO elects to permit clinicians to use an evidenced-based assessment tool other than CANS or ANSA, the MCO shall notify and receive approval of the specific tool from DHHS.

4.11.5.4.4 The assessment shall include the domains of the DSRIP Comprehensive Core Standardized Assessment and elements under review in the DHHS quality service review.

4.11.5.4.5 The MCO shall ensure that clinicians conducting or contributing to a Comprehensive Assessment are certified in the use of NH's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within one hundred and twenty (120) calendar days of implementation by DHHS of a web-based training and certification system.

4.11.5.4.6 The MCO shall require that certified clinicians use the CANS, ANSA, or an alternative evidenced-based assessment tool approved by DHHS for any newly evaluated Member and for an existing Member no later than at the Member's first eligibility renewal following certification.

4.11.5.5 Assertive Community Treatment Teams

4.11.5.5.1 The MCO shall work in collaboration with DHHS and CMH Programs/CMH Providers to ensure that ACT teams include at least one certified Peer Support Specialist and are available to Medicaid Members twenty-four (24) hours a day, seven (7) days a week, with on-call availability from 12:00 am to 8:00 am.

4.11.5.5.2 At the sole discretion of DHHS, as defined in separate guidance, the MCO shall reimburse CMH Programs/CMH Providers at an enhanced rate for the cost of providing at least fair fidelity ACT services to eligible Medicaid Members.

4.11.5.5.3 The MCO shall obtain annual fidelity review reports from DHHS to inform the ACT team's adherence to fidelity.

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4.11.5.5.4 In collaboration with DHHS, the MCO shall support CMH Programs/CMH Providers to achieve program improvement goals outlined in the ACT Quality Improvement Plan on file with DHHS to achieve full implementation of ACT.

4.11.5.5.5 In accordance with Exhibit O, the MCO shall report quarterly on the rate at which the MCO's Medicaid Members eligible for Community Mental Health Services are receiving ACT services.

4.11.5.5.6 The MCO shall provide updates on any waitlists maintained for ACT services during regular behavioral health meetings between the MCO and DHHS.

4.11.5.6 Mental Health Performance Improvement Project

4.11.5.6.1 [Amendment #8:] As outlined in Section 4.12.3.7 (Performance Improvement Projects), the MCO shall focus on the Department's objectives outlined in the NH MCM Quality Strategy. ~~engage in at least one (1) mental health PIP. The MCO shall satisfy this requirement by implementing a PIP designed to reduce Psychiatric Boarding in the ED.~~

4.11.5.7 Services for the Homeless

4.11.5.7.1 The MCO shall provide care to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services.

4.11.5.7.2 The MCO shall have one (1) or more Housing Coordinator(s) on staff or under contract to provide in-person housing assistance to Members who are homeless, as described in Section 3.15.1 (Key Personnel).

4.11.5.7.2.1. [Amendment #10:]. ~~[Amendment #9] [Amendment #8:] [Amendment #6:] [Amendment #5:]~~
For the period January 1, 2021 through August 31, 2024 ~~June 30, 2023 June 30 December 31, 2022-2021,~~
the Housing Coordinator position is not required.

4.11.5.7.3 The Housing Coordinator(s) shall coordinate with housing case managers at the CMH Programs, New Hampshire Hospital, the Bureau of Mental Health Services, the Bureau of Housing Supports and other CMH Providers to coordinate referrals.

4.11.5.7.4 In coordination with CMH Programs/CMH Providers, the MCO shall ensure that ACT teams and/or Housing Coordinator(s)

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also provide ongoing mental health and tenancy support services to Members.

4.11.5.7.5 In its contract with CMH Programs/CMH Providers, the MCO shall describe how it shall provide appropriate oversight of CMH Program/CMH Provider responsibilities, including:

4.11.5.7.5.1. Identifying housing options for Members at risk of experiencing homelessness;

4.11.5.7.5.2. Assisting Members in filing applications for housing and gathering necessary documentation;

4.11.5.7.5.3. Coordinating the provision of supportive housing; and

4.11.5.7.5.4. Coordinating housing-related services amongst CMH Programs/CMH Providers, the MCO and NH's Housing Bridge Subsidy Program.

4.11.5.7.6 The contract with CMH Programs/CMH Providers shall require quarterly assessments and documentation of housing status and homelessness for all Members.

4.11.5.7.7 The MCO shall ensure that any Member discharged into homelessness is connected to Care Management as described in Section 4.10.10 (Coordination and Integration with Social Services and Continuity of Care) within twenty-four (24) hours upon release.

4.11.5.8 Supported Employment

4.11.5.8.1 In coordination with CMH Programs/CMH Providers, the MCO shall actively promote EBSE to eligible Members.

4.11.5.8.2 The MCO shall obtain fidelity review reports from DHHS to inform EBSE team's adherence to fidelity with the expectation of at least good fidelity implementation for each CMH Program/CMH Provider.

4.11.5.8.3 In collaboration with DHHS, the MCO shall support the CMH Programs and CMH Providers to achieve program improvement goals outlined in the EBSE Quality Improvement Plan on file with DHHS to achieve full implementation of EBSE.

4.11.5.8.4 Based on data provided by DHHS, the MCO shall support DHHS's goals to ensure that at least nineteen percent (19%) of adult Members are engaged in EBSE services and that employment status is updated by the CMH Program/CMH Provider on a quarterly basis.

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4.11.5.8.5 The MCO shall report the EBSE rate to DHHS in accordance with Exhibit O and provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.9 Illness Management and Recovery

4.11.5.9.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of and increased penetration rates of illness management and Recovery to Members with SMI and SPMI.

4.11.5.9.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.10 Dialectical Behavioral Therapy

4.11.5.10.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of DBT to Members with diagnoses, including but not limited to SMI, SPMI, and Borderline Personality Disorder.

4.11.5.10.2 The MCO shall provide updates, such as the rate at which eligible Members receive meaningful levels of DBT services, as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.11 Peer Recovery Support Services

4.11.5.11.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of PRSS provided by Peer Recovery Programs in a variety of settings such as CMH Programs, New Hampshire Hospital, primary care clinics, and EDs.

4.11.5.11.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.12 Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems

4.11.5.12.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems²⁵ for children and youth Members experiencing anxiety, depression, trauma and conduct issues.

²⁵Available at: http://www.practicewise.com/portals/0/match_public/index.html

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4.11.5.12.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.13 First Episode Psychosis

4.11.5.13.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote the delivery of programming to address early symptoms of psychosis.

4.11.5.13.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.14 Child Parent Psychotherapy

4.11.5.14.1 In coordination with CMH Programs and CMH Providers, the MCO shall actively promote delivery of Child Parent Psychotherapy for young children.

4.11.5.14.2 The MCO shall provide updates as requested by DHHS during regular behavioral health meetings between the MCO and DHHS.

4.11.5.15 Implementation of New Hampshire's 10-Year Mental Health Plan

4.11.5.15.1 In accordance with Exhibit O, the MCO shall actively support the implementation of NH's 10-Year Mental Health Plan, updated periodically, to reinforce implementation of priorities outlined in the plan.

4.11.5.16 Changes in Healthy Behavior

4.11.5.16.1 The MCO shall promote Community Mental Health Service recipients' whole health goals to address health disparities.

4.11.5.16.2 Efforts can encompass interventions (e.g., tobacco cessation, "InShape") or other efforts designed to improve health.

4.11.5.16.3 The MCO shall gather smoking status data on all Members and report to DHHS in accordance with Exhibit O.

4.11.5.16.4 The MCO shall support CMH Programs/CMH Providers to establish incentive programs for Members to increase their engagement in healthy behavior change initiatives.

4.11.5.17 Reducing Psychiatric Boarding

4.11.5.17.1 For each hospital in its network, the MCO shall have on its own staff or contract with clinical Providers who are credentialed

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by the hospital (i.e., "hospital-credentialed Providers") to provide services to reduce Psychiatric Boarding stays.

4.11.5.17.1.1. [Amendment #10:] [Amendment #9:]
[Amendment #8:] [Amendment #6:] [Amendment #5:]
For the period January 1, 2021 through August 31, 2024~~June 30, 2023~~~~June 30, December 31, 2022~~ 2024,
the Psychiatric Boarding program's hospital-credentialed Provider position(s) described in Sections 4.11.5.17.1 through 4.11.5.17.4, and 4.11.5.17.6 are not required.

4.11.5.17.2 In meeting this requirement, the MCO cannot use CMH Programs and CMH Providers and shall ensure that its hospital-credentialed Providers are in addition to any capacity provided by CMH Programs and CMH Providers.

4.11.5.17.3 The MCO shall supply a sufficient number of hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to, or at risk for, Psychiatric Boarding.

4.11.5.17.4 The number of such hospital-credentialed Providers shall be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed.

4.11.5.17.5 [Amendment #8:] The initial on-site assistance provided within these required timelines shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or other State determined IMDs for mental illness or Substance Use Disorder services.

4.11.5.17.6 Each such hospital-credentialed Provider shall have the clinical expertise, inclusive of prescribing authority, to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required.

4.11.5.17.7 At the request of DHHS, the MCO shall participate in meetings with hospitals to address Psychiatric Boarding.

4.11.5.17.8 The MCO shall pay no less than the rate paid by NH Medicaid FFS program for all inpatient and outpatient service categories for billable services related to psychiatric boarding.

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4.11.5.17.9 [Amendment #8:] The MCO's capitation rates related to psychiatric services shall reflect utilization levels consistent with best practices for clinical path protocols, ED Psychiatric Boarding services, and discharge/readmission management at or from New Hampshire Hospital or other State determined IMDs for mental illness or Substance Use Disorder services.

4.11.5.17.10 The MCO shall describe its plan for reducing Psychiatric Boarding in its Annual Behavioral Health Strategy Plan and Report, in accordance with Exhibit O.

4.11.5.17.11 At minimum, the plan shall address how:

4.11.5.17.11.1. The MCO identifies when its Members are in the ED awaiting psychiatric placement or in a hospital setting awaiting an inpatient psychiatric bed;

4.11.5.17.11.2. Policies for ensuring a prompt crisis team consultation and face-to-face evaluation;

4.11.5.17.11.3. Strategies for identifying placement options or alternatives to hospitalization; and

4.11.5.17.11.4. Coordination with the CMH Programs/CMH Providers serving Members.

4.11.5.17.12 In accordance with Exhibit O, the MCO shall provide a monthly report on the number of its Members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult Members, and the rate of recidivism for Psychiatric Boarding.

4.11.5.18 [Amendment #8:] New Hampshire Hospital and Other State Determined IMDs for Mental Illness

4.11.5.18.1 [Amendment #8:] Agreements for New Hampshire Hospital Agreement and Other State Determined IMDs for Mental Illness

4.11.5.18.1.1. [Amendment #8:] The MCO shall maintain a written collaborative agreement with New Hampshire Hospital, ~~NH's State operated inpatient psychiatric facility~~ and other State determined IMDs for mental illness.

4.11.5.18.1.2. [Amendment #8:] This collaborative agreement shall be subject to the approval of DHHS and shall address the ADA requirement that Members be

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served in the most integrated setting appropriate to their needs, include the responsibilities of the CMH Program/CMH Provider to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and New Hampshire Hospital and other State determined IMDs for mental illness.

4.11.5.18.1.3. [Amendment #8:] The collaborative agreement shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to New Hampshire Hospital and other State determined IMDs for mental illness.

4.11.5.18.1.4. [Amendment #8:] Prior to admission to New Hampshire Hospital or other State determined IMDs for mental illness, the MCO shall ensure that a crisis team consultation has been completed for all Members evaluated by a licensed physician or psychologist.

4.11.5.18.1.5. The MCO shall ensure that a face-to-face evaluation by a mandatory pre-screening agent is conducted to assess eligibility for emergency involuntary admission to New Hampshire Hospital and determine whether all available less restrictive alternative services and supports are unsuitable.

4.11.5.18.2 Discharge Planning

4.11.5.18.2.1. [Amendment #8:] It is the policy of DHHS to avoid discharges from inpatient care at New Hampshire Hospital or other State determined IMDs for mental illness, to homeless shelters and to ensure the inclusion of an appropriate living situation as an integral part of all discharge planning ~~from New Hampshire Hospital.~~

4.11.5.18.2.2. The MCO shall track any Member discharges that the MCO, through its Provider network, was unable to place into the community and Members who instead were discharged to a shelter or into homelessness.

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4.11.5.18.2.3. [Amendment #8:] Also included in Section 3.15.2 (Other MCO Required Staff), the MCO shall designate an ~~off-site~~ on-site liaison with privileges, ~~as required by New Hampshire Hospital,~~ to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to New Hampshire Hospital or other State determined IMDs for mental illness.

4.11.5.18.2.4. [Amendment #8:] Except for participation in the Administrative Review Committee, the liaison shall actively participate in New Hampshire Hospital and other State determined IMDs for mental illness treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least restrictive environment complying with the ADA and other applicable State and federal regulations.

4.11.5.18.2.5. [Amendment #8:] The liaison shall actively participate, and assist New Hampshire Hospital and other State determined IMDs for mental illness staff in the development of a written discharge plan within twenty-four (24) hours of admission.

4.11.5.18.2.6. [Amendment #8:] The MCO shall ensure that the final New Hampshire Hospital or other State determined IMDs for mental illness discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight percent (98%) of Members discharged.

4.11.5.18.2.7. The MCO shall ensure that the discharge progress note shall be provided to the aftercare Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.11.5.18.2.8. For ACT team service recipients, the MCO shall ensure that the discharge progress note is provided to the Provider within twenty-four (24) hours of Member discharge.

4.11.5.18.2.9. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

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4.11.5.18.2.10. [Amendment #8:] The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from New Hampshire Hospital and other State determined IMDs for mental illness in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.11.5.18.2.11. The performance metric shall be that one hundred percent (100%) of Members discharged shall have been attempted to be contacted within three (3) business days.

4.11.5.18.2.12. For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the aftercare Provider and request that the aftercare Provider make contact with the Member within twenty-four (24) hours.

4.11.5.18.2.13. The MCO shall ensure an appointment with a CMH Program/CMH Provider or other appropriate mental health clinician is scheduled and that transportation has been arranged for the appointment prior to discharging a Member.

4.11.5.18.2.14. Such appointment shall occur within seven (7) calendar days after discharge.

4.11.5.18.2.15. ACT team service recipients shall be seen within twenty-four (24) hours of discharge.

4.11.5.18.2.16. For persons discharged from psychiatric hospitalization who are not a current client of the applicable CMH Program/CMH Provider, the Member shall have an intake appointment that is scheduled to occur within seven (7) calendar days after discharge.

4.11.5.18.2.17. [Amendment #8:] The MCO shall work with DHHS and the applicable CMH Program/CMH Provider to review cases of Members that New Hampshire Hospital and other State determined IMDs for mental illness ~~has~~ have indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.

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4.11.5.18.3 Administrative Days and Post Stabilization Care Services

4.11.5.18.3.1. [Amendment #8:] The MCO shall perform in-reach activities to New Hampshire Hospital and other State determined IMDs for mental illness designed to accomplish transitions to the community.

4.11.5.18.3.2. [Amendment #8:] Administrative days and post stabilization care services are inpatient hospital days associated with Members who no longer require acute care but are left in New Hampshire Hospital and other State determined IMDs for mental illness. ~~the hospital.~~

4.11.5.18.3.3. [Amendment #8:] The MCO shall pay New Hampshire Hospital and other State determined IMDs for mental illness for services delivered under the inpatient and outpatient service categories at rates no less than those paid by the NH Medicaid FFS program, inclusive of both State and federal share of the payment, if a Member cannot be discharged due to failure to provide appropriate community-based care and services.

4.11.5.18.4 Reduction in Behavioral Health Readmissions

4.11.5.18.4.1. [Amendment #8:] The MCO shall describe a reduction in readmissions plan in its annual Behavioral Health Strategy Plan and Report in accordance with Exhibit O, subject to approval by DHHS, to monitor the thirty (30)-day and one hundred and eighty (180)-day readmission rates to New Hampshire Hospital, other State determined IMDs for mental illness, designated receiving facilities and other equivalent facilities to review Member specific data with each of the CMH Programs/CMH Providers, and implement measurable strategies within ninety (90) calendar days of the execution of this Agreement to reduce thirty (30)-day and one hundred and eighty (180)-day readmission.

4.11.5.18.4.2. [Amendment #8:] Avoiding readmission is associated with the delivery of a full array of Medically Necessary outpatient medication and Behavioral Health Services in the ninety (90) days after discharge from New Hampshire Hospital and other State determined

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IMDs for mental illness; the MCO shall ensure provision of appropriate service delivery in the ninety (90) days after discharge.

4.11.5.18.4.3. [Amendment #8:] For Members with readmissions to any inpatient psychiatric setting within thirty (30) days and one hundred and eighty (180) days, the MCO shall report on the mental health and related service utilization that directly preceded readmission in accordance with Exhibit O. This data shall be shared with the Member's CMH Program/CMH Provider, if applicable, and DHHS in order to evaluate if appropriate levels of care were provided to decrease the likelihood of re-hospitalization.

4.11.6 Substance Use Disorder

4.11.6.1 The MCO's policies and procedures related to Substance Use Disorder shall be in compliance with State and federal law, including but not limited to, Chapter 420-J, Section J:15 through Section J:19 and shall comply with all State and federal laws related to confidentiality of Member behavioral health information.

4.11.6.2 In addition to services covered under the Medicaid State Plan, the MCO shall cover the services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder benefits. [42 CFR 438, subpart K; 42 CFR 438.3(e)(1)(ii)]

4.11.6.3 The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.11.6.4 Contracting for Substance Use Disorder

4.11.6.4.1 The MCO shall contract with Substance Use Disorder service programs and Providers to deliver Substance Use Disorder services for eligible Members, as defined in He-W 513.²⁶

4.11.6.4.2 The contract between the MCO and the Substance Use Disorder programs and Participating Providers shall be submitted to DHHS for review and approval prior to implementation in accordance with Section 3.14.2 (Contracts with Subcontractors).

4.11.6.4.3 The contract shall, at minimum, address the following:

4.11.6.4.3.1. The scope of services to be covered;

²⁶ Available at http://www.gencourt.state.nh.us/rules/state_agencies/he-w.html

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4.11.6.4.3.2. Compliance with the requirements of this Agreement and applicable State and federal law;

4.11.6.4.3.3. The role of the MCO versus the Substance Use Disorder program and/or Provider;

4.11.6.4.3.4. procedures for communication and coordination between the MCO and the Substance Use Disorder program and/or Provider;

4.11.6.4.3.5. Other Providers serving the same Member, and DHHS as applicable;

4.11.6.4.3.6. The approach to payment, including enhanced payment for ACT services;

4.11.6.4.3.7. Data sharing on Members;

4.11.6.4.3.8. Data reporting between the Substance Use Disorder programs and/or Providers and the MCO, and DHHS as applicable; and

4.11.6.4.3.9. Oversight, enforcement, and remedies for contract disputes.

4.11.6.4.4 The contract shall provide for monitoring of Substance Use Disorder service performance through quality metrics and oversight procedures specified in the contract.

4.11.6.4.5 When contracting with Peer Recovery Programs, the MCO shall contract with all Willing Providers in the State through the PRSS Facilitating Organization or other accrediting body approved by DHHS, unless the Provider requests a direct contract.

4.11.6.4.6 The MCO shall reimburse Peer Recovery Programs in accordance with rates that are no less than the equivalent DHHS FFS rates.

4.11.6.4.7 When contracting with methadone clinics, the MCO shall contract with and have in its network all Willing Providers in the state.

4.11.6.5 Payment to Substance Use Disorder Providers

4.11.6.5.1 The MCO shall reimburse Substance Use Disorder Providers in accordance with rates that are no less than the equivalent DHHS FFS rates.

4.11.6.5.2 The MCO need not pay using DHHS's FFS mechanism where the MCO's contract with the Provider meets the following requirements:

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4.11.6.5.2.1. Is subject to enhanced reimbursement for MAT, as described in as outlined in this section; or

4.11.6.5.2.2. Falls under a DHHS-approved APM, the standards and requirements for obtaining DHHS approval are further described in Section 4.14 (Alternative Payment Models).

4.11.6.5.3 DHHS shall provide the MCO with sixty (60) calendar days' advance notice prior to any change to reimbursement.

4.11.6.5.4 In accordance with Exhibit O, the MCO shall develop and submit to DHHS, a payment plan for offering enhanced reimbursement to qualified physicians who are SAMHSA certified to dispense or prescribe MAT.

4.11.6.5.5 The plan shall indicate at least two (2) tiers of enhanced payments that the MCO shall make to qualified Providers based on whether Providers are certified and providing MAT to up to thirty (30) Members per quarter (i.e., tier one (1) Providers) or certified and providing MAT to up to one hundred (100) Members per quarter (i.e., tier two (2) Providers).

4.11.6.5.6 The tier determinations that qualify Providers for the MCO's enhanced reimbursement policy shall reflect the number of Members to whom the Provider is providing MAT treatment services, not the number of patients the Provider is certified to provide MAT treatment to.

4.11.6.5.7 The MCO shall develop at least one (1) APM designed to increase access to MAT for Substance Use Disorder and one (1) APM (such as a bundled payment) for the treatment of babies born with NAS.

4.11.6.6 Provision of Substance Use Disorder Services

4.11.6.6.1 The MCO shall ensure that Substance Use Disorder services are provided in accordance with the Medicaid State Plan and He-W 513. This includes, but is not limited to:

4.11.6.6.1.1. Ensuring that the full continuum of care is appropriately provided to eligible Members;

4.11.6.6.1.2. Ensuring that eligible Members are provided with Recovery support services; and

4.11.6.6.1.3. Ensuring that eligible Members are provided with coordinated care when entering or leaving a treatment program.

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4.11.6.6.2 The MCO shall ensure that all Providers providing Substance Use Disorder services comply with the requirements of He-W 513.

4.11.6.6.3 The MCO shall work in collaboration with DHHS and Substance Use Disorder programs and/or Providers to support and sustain evidenced-based practices that have a profound impact on Provider and Member outcomes, including, but is not limited to, enhanced rate or incentive payments for evidenced-based practices.

4.11.6.6.4 The MCO shall ensure that the full continuum of care required for Members with Substance Use Disorders is available and provided to Members in accordance with NH Code of Administrative Rules, Chapter He-W 500, Part He-W 513.

4.11.6.6.5 This includes, but is not limited to:

4.11.6.6.5.1. Ensuring that Members at risk of experiencing Substance Use Disorder are assessed using a standardized evidence-based assessment tool consistent with ASAM Criteria; and

4.11.6.6.5.2. Providing access to the full range of services available under the DHHS's Substance Use Disorder benefit, including Peer Recovery Support without regard to whether Peer Recovery Support is an aspect of an additional service provided to the Member.

4.11.6.6.6 The MCO shall make PRSS available to Members both as a standalone service (regardless of an assessment), and as part of other treatment and Recovery services.

4.11.6.6.7 The provision of services to recipients enrolled in an MCO shall not be subject to more stringent service coverage limits than specified under this Agreement or State Medicaid policies.

4.11.6.7 Substance Use Disorder Clinical Evaluations and Treatment Plans

4.11.6.7.1 The MCO shall ensure, through its regular quality improvement activities and reviews of DHHS administered quality monitoring and improvement activities, that Substance Use Disorder treatment services are delivered in the least restrictive community based environment possible and based on a person-centered approach where the Member and their family's personal goals and needs are considered central in the development of the Individualized service plans.

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4.11.6.7.2 A Clinical Evaluation is a biopsychosocial evaluation completed in accordance with SAMHSA Technical Assistance Publication (TAP) 21: Addiction Counseling Competencies.

4.11.6.7.3 The MCO shall ensure that all services provided include a method to obtain clinical evaluations using DSM five (5) diagnostic information and a recommendation for a level of care based on the ASAM Criteria, published in October, 2013 or as revised by ASAM.

4.11.6.7.4 The MCO shall ensure that a clinical evaluation is completed for each Member prior to admission as a part of interim services or within three (3) business days following admission.

4.11.6.7.5 For a Member being transferred from or otherwise referred by another Provider, the Provider shall use the clinical evaluation completed by a licensed behavioral health professional from the referring agency, which may be amended by the receiving Provider.

4.11.6.7.6 The Provider shall complete individualized treatment plans for all Members based on clinical evaluation data within three (3) business days of the clinical evaluation, that address problems in all ASAM 2013 domains which justify the Member's admittance to a given level of care and that include individualized treatment plan goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART).

4.11.6.7.7 The treatment plan shall include the Member's involvement in identifying, developing, and prioritizing goals, objectives, and interventions.

4.11.6.7.8 Treatment plans shall be updated based on any changes in any ASAM domain and no less frequently than every four (4) sessions or every four (4) weeks, whichever is less frequent.

4.11.6.7.9 The treatment plan updates much include:

4.11.6.7.9.1. Documentation of the degree to which the Member is meeting treatment plan goals and objectives;

4.11.6.7.9.2. Modification of existing goals or addition of new goals based on changes in the Member's functioning relative to ASAM domains and treatment goals and objectives;

4.11.6.7.9.3. The counselor's assessment of whether or not the Member needs to move to a different level of

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care based on ASAM continuing care, transfer and discharge criteria; and

4.11.6.7.9.4. The signature of the Member and the counselor agreeing to the updated treatment plan, or if applicable, documentation of the Member's refusal to sign the treatment plan.

4.11.6.8 Substance Use Disorder Performance Improvement Project

4.11.6.8.1 In compliance with the requirements outlined in Section 4.12.3 (Quality Assessment and Performance Improvement Program), the MCO shall, at a minimum, conduct at least one (1) PIP designed to improve the delivery of Substance Use Disorder services.

4.11.6.9 Reporting

4.11.6.9.1 The MCO shall report to DHHS Substance Use Disorder-related metrics in accordance with Exhibit O including, but not limited to, measures related to access to services, engagement, clinically appropriate services, Member engagement in treatment, treatment retention, safety monitoring, and service utilization.

4.11.6.9.2 The MCO shall provide, in accordance with Exhibit O, an assessment of any prescribing rate and pattern outliers and how the MCO plans to follow up with Providers identified as having high-prescribing patterns.

4.11.6.9.3 [Amendment #7:] The MCO shall utilize audit tool(s) provided by or approved by DHHS, collected via one or more mediums made available or approved by DHHS, to assess the activities of Substance Use Disorder Providers and Opioid Treatment Programs (OTPs), to ensure compliance with the He-W 513 rules, He-A 304 rules, and the MCO Contract. The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.11.6.9.3.1. [Amendment #7:] The MCO shall provide to DHHS copies of all findings from any audit or assessment of Providers related to Substance Use Disorder conducted by the MCO or on behalf of the MCO.

4.11.6.9.3.2. [Amendment #7:] The MCO shall report on SUD Provider compliance with service provisions

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outlined in the SUD audit tool in accordance with Exhibit O.

4.11.6.9.4 On a monthly basis, the MCO shall provide directly to Participating Providers comparative prescribing data, including the average Morphine Equivalent Dosing (MED) levels across patients and identification of Members with MED at above average levels, as determined by the MED levels across Members.

4.11.6.9.5 The MCO shall also provide annual training to Participating Providers.

4.11.6.10 Services for Members Who are Homeless or At-Risk of Homelessness

4.11.6.10.1 In coordination with Substance Use Disorder programs and/or Providers, the MCO shall provide care to Members who are homeless or at risk of homelessness as described in Section 4.11.5.7 (Services for the Homeless).

4.11.6.11 Peer Recovery Support Services

4.11.6.11.1 In coordination with Peer Recovery Programs and Peer Recovery Coaches, as defined in He-W 513, the MCO shall actively promote delivery of PRSS provided by Peer Recovery Coaches who are also certified Recovery support workers in a variety of settings such as Peer Recovery Programs, clinical Substance Use Disorder programs, EDs, and primary care clinics.

4.11.6.12 Naloxone Availability

4.11.6.12.1 The MCO shall work with each contracted Substance Use Disorder program and/or Provider to ensure that naloxone kits are available on-site and training on naloxone administration and emergency response procedures are provided to program and/or Provider staff at a minimum annually.

4.11.6.13 Prescription Drug Monitoring Program

4.11.6.13.1 The MCO shall include in its Provider agreements the requirement that prescribers and dispensers comply with the NH PDMP requirements, including but not limited to opioid prescribing guidelines.

4.11.6.13.2 The Provider agreements shall require Participating Providers to provide to the MCO, to the maximum extent possible, data on substance dispensing to Members prior to releasing such medications to Members.

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4.11.6.13.3 The MCO shall monitor harmful prescribing rates and, at the discretion of DHHS, may be required to provide ongoing updates on those Participating Providers who have been identified as overprescribing.

4.11.6.14 Response After Overdose.

4.11.6.14.1 Whenever a Member receives emergency room or inpatient hospital services as a result of a non-fatal overdose, the MCO shall work with hospitals to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the MCO and the participating hospital.

4.11.6.14.2 Whenever a Member discharges themselves against medical advice, the MCO shall make a good faith effort to ensure that the Member receives a clinical evaluation, referral to appropriate treatment, Recovery support services and intense Case Management within forty-eight (48) hours of discharge or the MCO being notified, whichever is sooner.

4.11.6.15 Limitations on Prior Authorization Requirements

4.11.6.15.1 To the extent permitted under State and federal law, the MCO shall cover MAT.

4.11.6.15.2 Methadone received at a methadone clinic shall not require Prior Authorization.

4.11.6.15.3 Methadone used to treat pain shall require Prior Authorization.

4.11.6.15.3.1. Any Prior Authorization for office based MAT shall comply with RSA 420-J:17 and RSA 420-J:18.

4.11.6.15.4 The MCO shall not impose any Prior Authorization requirements for MAT urine drug screenings (UDS) unless a Provider exceeds thirty (30) UDSs per month per treated Member.

4.11.6.15.4.1. In the event a Provider exceeds thirty (30) UDS per month per treated Member, the MCO shall impose Prior Authorization requirements on usage.

4.11.6.15.5 The MCO is precluded from imposing any Prior Authorization on screening for multiple drugs within a daily drug screen.

4.11.6.15.6 [Amendment #6:] The MCO may require prior authorization for SUD treatments, excluding MAT services as

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~~described in Section 4.11.6.15.3.1. The MCO shall cover without Prior Authorization or other Utilization Management restrictions any treatments identified as necessary by a clinician trained in the use and application of the ASAM Criteria.~~

4.11.6.15.6.1. [Amendment #6:] The MCO shall utilize ASAM Criteria when determining medical necessity for continuation of covered services.

4.11.6.15.6.2. [Amendment #6:] Nothing in this section shall be construed to require coverage for services provided by a non-participating provider.

4.11.6.15.6.3. [Amendment #6:] The MCO may require prior authorization for covered services only if the MCO has a medical clinician or licensed alcohol and drug counselor available on a 24-hour hotline to make the medical necessity determination and assist with placement at the appropriate level of care, and the MCO provides a prior authorization decision as soon as practicable after receipt from the treating clinician of the clinical rationale consistent with the ASAM criteria, but in no event more than 6 hours of receiving such information; provided that until such hotline determination is made, coverage for substance use disorder services shall be provided at an appropriate level of care consistent with the ASAM criteria, as defined in RSA 420-J:15, I.

~~4.11.6.15.7 [Amendment #6:] Intentionally left blank. Should the MCO have concerns about the appropriateness of a course of treatment after the treatment has commenced, the MCO shall contact the Provider to request additional information and/or recommend a change, but shall continue to pay for the treatment unless and until the Provider determines an alternative type of treatment or setting is appropriate.~~

4.11.6.15.8 DHHS shall monitor utilization of Substance Use Disorder treatment services to identify, prevent, and correct potential occurrences of fraud, waste and abuse, in accordance with 42 CFR 455 and 42 CFR 456 and He-W 520.

4.11.6.15.9 DHHS may grant exceptions to this provision in instances where it is necessary to prevent fraud, waste and abuse.

4.11.6.15.10 For Members who enter the Pharmacy Lock-In Program as described in Section 4.2.3 (Clinical Policies and Prior

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Authorizations), the MCO shall evaluate the need for Substance Use Disorder treatment.

4.11.6.16 Opioid Prescribing Requirements

4.11.6.16.1 The MCO shall require Prior Authorization documenting the rationale for the prescriptions of more than one hundred (100) mg daily MED of opioids for Members.

4.11.6.16.2 As required under the NH Board Administrative Rule MED 502 Opioid Prescribing, the MCO shall adhere to MED procedures for acute and chronic pain, taking actions, including but not limited to:

4.11.6.16.2.1. A pain management consultation or certification from the Provider that it is due to an acute medical condition;

4.11.6.16.2.2. Random and periodic UDS; and

4.11.6.16.2.3. Utilizing written, informed consent.

4.11.6.16.3 The MCO shall ensure that Participating Providers prescribe and dispense Naloxone for patients receiving a one hundred (100) mg MED or more per day for longer than ninety (90) calendar days.

4.11.6.16.4 If the NH Board Administrative Rule MED 502 Opioid Prescribing is updated in the future, the MCO shall implement the revised policies in accordance with the timelines established or within sixty (60) calendar days if no such timeline is provided.

4.11.6.17 Neonatal Abstinence Syndrome

4.11.6.17.1 For those Members with a diagnosis of Substance Use Disorder and all infants with a diagnosis of NAS, or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall provide Care Management services to provide for coordination of their physical and behavioral health, according to the safeguards relating to re-disclosure set out in 42 CFR Part 2.

4.11.6.17.2 Substance Use Disorder Care Management features shall include, but not be limited to:

4.11.6.17.2.1. Conducting outreach to Members who would benefit from treatment (for example, by coordinating with emergency room staff to identify and engage with Members admitted to the ED following an overdose),

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4.11.6.17.2.2. Ensuring that Members are receiving the appropriate level of Substance Use Disorder treatment services,

4.11.6.17.2.3. Scheduling Substance Use Disorder treatment appointments and following up to ensure appointments are attended, and

4.11.6.17.2.4. Coordinating care among prescribing Providers, clinician case managers, pharmacists, behavioral health Providers and social service agencies.

4.11.6.17.2.5. The MCO shall make every attempt to coordinate and enhance Care Management services being provided to the Member by the treating Provider.

4.11.6.17.3 The MCO shall work with DCYF to provide Substance Use Disorder treatment referrals and conduct a follow-up after thirty (30) calendar days to determine the outcome of the referral and determine if additional outreach and resources are needed.

4.11.6.17.4 The MCO shall work with DCYF to ensure that health care Providers involved in the care of infants identified as being affected by prenatal drug or alcohol exposure, create and implement the Plan of Safe Care.

4.11.6.17.4.1. The Plan of Safe Care shall be developed in collaboration with health care Providers and the family/caregivers of the infant to address the health of the infant and Substance Use Disorder treatment needs of the family or caregiver.

4.11.6.17.5 The MCO shall establish protocols for Participating Providers to implement a standardized screening and treatment protocol for infants at risk of NAS.

4.11.6.17.6 The MCO shall provide training to Providers serving infants with NAS on best practices, including:

4.11.6.17.6.1. Opportunities for the primary care giver(s) to room-in;

4.11.6.17.6.2. Transportation and childcare for the primary care giver(s);

4.11.6.17.6.3. Priority given to non-pharmaceutical approaches (e.g., quiet environment, swaddling);

4.11.6.17.6.4. Education for primary care giver(s) on caring for newborns;

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4.11.6.17.6.5. Coordination with social service agencies providing supports, including coordinated case meetings and appropriate developmental services for the infant;

4.11.6.17.6.6. Information on family planning options; and

4.11.6.17.6.7. Coordination with the family and Providers on the development of the Plan of Safe Care for any infant born with NAS.

4.11.6.17.7 The MCO shall work with DHHS and Providers eligible to expand/develop services to increase capacity for specialized services for this population which address the family as a unit and are consistent with Northern New England Perinatal Quality Improvement Network's (NNEPQIN) standards.

4.11.6.18 Discharge Planning

4.11.6.18.1 In all cases where the MCO is notified or otherwise learns that a Member has had an ED visit or is hospitalized for an overdose or Substance Use Disorder, the MCO's Care Coordination staff shall actively participate and assist hospital staff in the development of a written discharge plan.

4.11.6.18.2 The MCO shall ensure that the final discharge instruction sheet shall be provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight (98%) of Members discharged.

4.11.6.18.3 The MCO shall ensure that the discharge progress note shall be provided to any treatment Provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged.

4.11.6.18.3.1. If a Member lacks a reasonable means of communicating with a plan prior to discharge, the MCO shall identify an alternative viable means for communicating with the Member in the discharge plan.

4.11.6.18.4 It is the expectation of DHHS that Members treated in the ED or inpatient setting for an overdose are not to be released to the community without outreach from the MCO or provided with referrals for an evaluation and treatment.

4.11.6.18.5 The MCO shall track all Members discharged into the community who do not receive MCO contact (including outreach or a referral to a Substance Use Disorder program and/or Provider).

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4.11.6.18.6 The MCO shall make at least three (3) attempts to contact Members within three (3) business days of discharge from the ED to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

4.11.6.18.7 At least ninety-five percent (95%) of Members discharged shall have been attempted to be contacted within three (3) business days.

4.11.6.18.8 For any Member the MCO does not make contact with within three (3) business days, the MCO shall contact the treatment Provider and request that the treatment Provider make contact with the Member within twenty-four (24) hours.

4.11.6.18.9 The MCO shall ensure an appointment for treatment other than evaluation with a Substance Use Disorder program and/or Provider for the Member is scheduled prior to discharge when possible and that transportation has been arranged for the appointment. Such appointments shall occur within seven (7) calendar days after discharge.

4.11.6.18.10 In accordance with 42 CFR Part 2, the MCO shall work with DHHS during regularly scheduled meetings to review cases of Members that have been seen for more than three (3) overdose events within a thirty (30) calendar day period or those that have had a difficulty engaging in treatment services following referral and Care Coordination provided by the MCO.

4.11.6.18.11 The MCO shall also review Member cases with the applicable Substance Use Disorder program and/or Provider to promote strategies for reducing overdoses and increase engagement in treatment services.

4.12 Quality Management

4.12.1 **General Provisions**

4.12.1.1 The MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

4.12.1.2 [Amendment #7:] The MCO shall work in collaboration with DHHS, Members and Providers to actively improve the quality of

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care provided to Members, consistent with the MCO's quality improvement goals and all other requirements of the Agreement.

4.12.1.2.1 [Amendment #7:] The MCO shall conduct reviews and audits of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP), as described in separate guidance.

4.12.1.3 The MCO shall provide mechanisms for Member Advisory Board and the Provider Advisory Board to actively participate in the MCO's quality improvement activities.

4.12.1.4 The MCO shall support and comply with the most current version of the Quality Strategy for the MCM program.

4.12.1.5 The MCO shall approach all clinical and non-clinical aspects of QAPI based on principles of CQI/Total Quality Management and shall:

4.12.1.5.1 Evaluate performance using objective quality indicators and recognize that opportunities for improvement are unlimited;

4.12.1.5.2 Foster data-driven decision-making;

4.12.1.5.3 Solicit Member and Provider input on the prioritization and strategies for QAPI activities;

4.12.1.5.4 Support continuous ongoing measurement of clinical and non-clinical health plan effectiveness, health outcomes improvement and Member and Provider satisfaction;

4.12.1.5.5 Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

4.12.1.5.6 Support re-measurement of effectiveness, health outcomes improvement and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

4.12.2 Health Plan Accreditation

4.12.2.1 The MCO shall achieve health plan accreditation from the NCQA, including the NCQA Medicaid Module.

4.12.2.2 If the MCO participated in the MCM program prior to the Program Start Date, the MCO shall maintain its health plan accreditation status throughout the period of the Agreement, and

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complete the NCQA Medicaid Module within eighteen (18) months of the Program Start Date.

4.12.2.3 If the MCO is newly participating in the MCM program, the MCO shall achieve health plan accreditation from NCQA, including the Medicaid Module, within eighteen (18) months of the Program Start Date.

4.12.2.4 To demonstrate its progress toward meeting this requirement, the newly participating MCO shall complete the following milestones:

4.12.2.4.1 Within sixty (60) calendar days of the Program Start Date, the MCO shall notify DHHS of the initiation of the process to obtain NCQA Health Plan Accreditation; and

4.12.2.4.2 Within thirty (30) calendar days of the date of the NCQA survey on-site review, the MCO shall notify DHHS of the date of the scheduled on-site review.

4.12.2.5 The MCO shall inform DHHS of whether it has been accredited by any private independent accrediting entity, in addition to NCQA Health Plan Accreditation.

4.12.2.6 The MCO shall authorize NCQA, and any other entity from which it has received or is attempting to receive accreditation, to provide a copy of its most recent accreditation review to DHHS, including [42 CFR 438.332(a)]:

4.12.2.6.1 Accreditation status, survey type, and level (as applicable);

4.12.2.6.2 Accreditation results, including recommended actions or improvements, CAPs, and summaries of findings; and

4.12.2.6.3 Expiration date of the accreditation. [42 CFR 438.332(b)(1)-(3)]

4.12.2.7 To avoid duplication of mandatory activities with accreditation reviews, DHHS may indicate in its quality strategy the accreditation review standards that are comparable to the standards established through federal EQR protocols and that DHHS shall consider met on the basis of the MCO's achievement of NCQA accreditation. [42 CFR 438.360]

4.12.2.8 An MCO going through an NCQA renewal survey shall complete the full Accreditation review of all NCQA Accreditation Standards.

4.12.2.9 During the renewal survey, the MCO shall:

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4.12.2.9.1 Request from NCQA the full review of all NCQA Accreditation Standards and cannot participate in the NCQA renewal survey option that allows attestation for certain requirements; and

4.12.2.9.2 Submit to DHHS a written confirmation from NCQA stating that the renewal survey for the MCO will be for all NCQA Accreditation Standards without attestation.

4.12.3 Quality Assessment and Performance Improvement Program

4.12.3.1 The MCO shall have an ongoing comprehensive QAPI program for the services it furnishes to Members consistent with the requirements of this Agreement and federal requirements for the QAPI program [42 CFR 438.330(a)(1); 42 CFR 438.330(a)(3)].

4.12.3.2 The MCO's QAPI program shall be documented in writing (in the form of the "QAPI Plan"), approved by the MCO's governing body, and submitted to DHHS for its review annually.

4.12.3.3 In accordance with Exhibit O, the QAPI Plan shall contain, at a minimum, the following elements:

4.12.3.3.1 A description of the MCO's organization-wide QAPI program structure;

4.12.3.3.2 The MCO's annual goals and objectives for all quality activities, including but not limited to:

4.12.3.3.2.1. DHHS-required PIPs,

4.12.3.3.2.2. DHHS-required quality performance data,

4.12.3.3.2.3. DHHS-required quality reports, and

4.12.3.3.2.4. Implementation of EQRO recommendations from annual technical reports;

4.12.3.3.3 Mechanisms to detect both underutilization and overutilization of services [42 CFR 438.330(b)(3)];

4.12.3.3.4 Mechanisms to assess the quality and appropriateness of care for Members with Special Health Care Needs (as defined by DHHS in the quality strategy) [42 CFR 438.330(b)(4)] in order to identify any Ongoing Special Conditions of a Member that require a course of treatment or regular care monitoring;

4.12.3.3.5 Mechanisms to assess and address disparities in the quality of, and access to, health care, based on age, race, ethnicity, sex, primary language, and disability status (defined as whether the

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individual qualified for Medicaid on the basis of a disability) [42 CFR 438.340(b)(6)]; and

4.12.3.3.6 The MCO's systematic and ongoing process for monitoring, evaluation and improvement of the quality and appropriateness of Behavioral Health Services provided to Members.

4.12.3.4 The MCO shall maintain a well-defined QAPI program structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, the MCO shall ensure that the QAPI program structure:

4.12.3.4.1 Is organization-wide, with clear lines of accountability within the organization;

4.12.3.4.2 Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, clinicians, and non-clinicians;

4.12.3.4.3 Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

4.12.3.4.4 Evaluates the effectiveness of clinical and non-clinical initiatives.

4.12.3.5 If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI program to another entity, the MCO shall maintain detailed files documenting work performed by the Subcontractor. The file shall be available for review by DHHS or its designee upon request, and a summary of any functions that have been delegated to Subcontractor(s) shall be indicated within the MCO's QAPI Plan submitted to DHHS annually.

4.12.3.6 Additional detail regarding the elements of the QAPI program and the format in which it should be submitted to DHHS is provided in Exhibit O.

4.12.3.7 Performance Improvement Projects .

4.12.3.7.1 The MCO shall conduct any and all PIPs required by CMS. [42 CFR 438.330(a)(2)]

4.12.3.7.2 [Amendment #5:] Throughout the five-year contract period, Annually, the MCO shall conduct at least three (3) clinical PIPs that meet the following criteria [42 CFR 438.330 (d)(1)]:

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4.12.3.7.2.1. [Amendment #8:] At least one (1) clinical PIP shall have a focus on the Department's objectives outlined in the NH MCM Quality Strategy reducing Psychiatric Boarding in the ED for Medicaid enrollees (regardless of whether they are Medicaid-Medicare dual individuals), as defined in Section 4.11.5 (Mental Health);

4.12.3.7.2.2. At least one (1) clinical PIP shall have a focus on Substance Use Disorder, as defined in Section 4.11.6 (Substance Use Disorder);

4.12.3.7.2.3. At least (1) clinical PIP shall focus on improving quality performance in an area that the MCO performed lower than the fiftieth (50th) percentile nationally, as documented in the most recent EQRO technical report or as otherwise indicated by DHHS.

4.12.3.7.2.4. [Amendment #5:] If the MCO's individual experience is not reflected in the most recent EQRO technical report, the MCO shall incorporate a PIP in an area that the MCOs participating in the MCM program at the time of the most recent EQRO technical report performed below the ~~fiftieth (50th)~~ seventy-fifth (75th) percentile.

4.12.3.7.2.5. [Amendment #5:] Should no quality measure have a lower than ~~fiftieth (50th)~~ seventy-fifth (75th) percentile performance, the MCO shall focus the PIP on one (1) of the areas for which its performance (or, in the event the MCO is not represented in the most recent report, the other MCOs' collective performance) was lowest.

4.12.3.7.3 [Amendment #7:] Throughout the five-year contract ~~Annually~~, the MCO shall conduct at least one (1) non-clinical PIP, which shall be related to one (1) of the following topic areas and approved by DHHS:

4.12.3.7.3.1. Addressing social determinants of health;

4.12.3.7.3.2. Integrating physical and behavioral health.

4.12.3.7.4 The non-clinical PIP may include clinical components, but shall have a primary focus on non-clinical outcomes.

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4.12.3.7.5 The MCO shall ensure that each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction [42 CFR 438.330(d)(2)], and shall include the following elements:

4.12.3.7.5.1. Measurement(s) of performance using objective quality indicators [42 CFR 438.330(d)(2)(i)];

4.12.3.7.5.2. Implementation of interventions to achieve improvement in the access to and quality of care [42 CFR 438.330(d)(2)(ii)];

4.12.3.7.5.3. Evaluation of the effectiveness of the interventions based on the performance measures used as objective quality indicators [42 CFR 438.330(d)(2)(iii)]; and

4.12.3.7.5.4. Planning and initiation of activities for increasing or sustaining improvement [42 CFR 438.330(d)(2)(iv)].

4.12.3.7.6 Each PIP shall be approved by DHHS and shall be completed in a reasonable time period so as to generally permit information on the success of PIPs in the aggregate to produce new information on quality of care every year.

4.12.3.7.7 In accordance with Exhibit O, the MCO shall include in its QAPI Plan, to be submitted to DHHS annually, the status and results of each PIP conducted in the preceding twelve (12) months and any changes it plans to make to PIPs or other MCO processes in the coming years based on these results or other findings [42 CFR 438.330(d)(1) and (3)].

4.12.3.7.8 [Amendment #3:] At the sole discretion of DHHS, the PIPs may be delayed in the event of a public health emergency.

4.12.3.8 Member Experience of Care Survey

4.12.3.8.1 The MCO shall be responsible for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on an annual basis, and as required by NCQA for Medicaid health plan accreditation for both adults and children, including:

4.12.3.8.1.1. CAHPS Health Plan Survey 5.0H, Adult Version or later version as specified by DHHS;

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4.12.3.8.1.2. CAHPS Health Plan Survey 5.0H, Child Version with Children with Chronic Conditions Supplement or later version as specified by DHHS.

4.12.3.8.2 Each CAHPS survey administered by the MCO shall include up to twelve (12) other supplemental questions for each survey as defined by DHHS and indicated in Exhibit O. Supplemental questions, including the number, are subject to NCQA approval.

4.12.3.8.3 The MCO shall obtain DHHS approval of instruments prior to fielding the CAHPS surveys.

4.12.3.9 Quality Measures

4.12.3.9.1 The MCO shall report the following quality measure sets annually according to the current industry/regulatory standard definitions, in accordance with Exhibit O [42 CFR 438.330(b)(2); 42 CFR 438.330(c)(1) and (2); 42 CFR 438.330(a)(2)]:

4.12.3.9.1.1. CMS Child Core Set of Health Care Quality Measures for Medicaid and CHIP, as specified by DHHS;

4.12.3.9.1.2. CMS Adult Core Set of Health Care Quality Measures for Medicaid, as specified by DHHS;

4.12.3.9.1.3. [Amendment #6:] NCQA Medicaid Accreditation measures, including race and ethnicity stratification, which shall be generated without NCQA Allowable Adjustments and validated by submission to NCQA;

4.12.3.9.1.3.1 [Amendment #7] The MCO shall include supplemental data in HEDIS measures identified in Exhibit O for NCQA Accreditation and reporting through Interactive Data Submission System.

4.12.3.9.1.3.2 [Amendment #8:] The MCO shall report Member level data for audited HEDIS measures as identified in Exhibit O.

4.12.3.9.1.4. All available CAHPS measures and sections and additional supplemental questions defined by DHHS;

4.12.3.9.1.5. Any CMS-mandated measures [42 CFR 438.330(c)(1)(i)];

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4.12.3.9.1.6. Select measures to monitor MCO Member and Provider operational quality and Care Coordination efforts;

4.12.3.9.1.7. [Amendment #7:] Select measures specified by DHHS as priority measures for use in assessing and addressing local challenges to high-quality care and access; ~~and~~

4.12.3.9.1.8. [Amendment #7:] Measures indicated by DHHS as a requirement for fulfilling CMS waiver requirements; and

4.12.3.9.1.9. [Amendment #7] Measures indicated by DHHS as a requirement for the CMS Managed Care Program Annual Report [42 CFR 438.66(e)].

4.12.3.9.2 Consistent with State and federal law, and utilizing all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information, the MCO shall collaborate in data collection with the Integrated Delivery Networks for clinical data collected for quality and performance measures common between the MCM program and the DSRIP program to reduce duplication of effort in collection of data.

4.12.3.9.3 The MCO shall report all quality measures in accordance with Exhibit O, regardless of whether the MCO has achieved accreditation from NCQA.

4.12.3.9.4 The MCO shall submit all quality measures in the formats and schedule in Exhibit O or otherwise identified by DHHS. This includes , as determined by DHHS:

4.12.3.9.4.1. Gain access to and utilize the NH Medicaid Quality Information System, including participating in any DHHS-required training necessary;

4.12.3.9.4.2. Attend all meetings with the relevant MCO subject matter experts to discuss specifications for data indicated in Exhibit O; and

4.12.3.9.4.3. Communicate and distribute all specifications and templates provided by DHHS for measures in Exhibit O to all MCO subject matter experts involved in the production of data in Exhibit O.

4.12.3.9.5 If additional measures are added to the NCQA or CMS measure sets, the MCO shall include any such new measures in its reports to DHHS.

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4.12.3.9.6 For measures that are no longer part of the measure sets, DHHS may, at its option, continue to require those measures; any changes to MCO quality measure reporting requirements shall be communicated to MCOs and documented within a format similar to Exhibit O.

4.12.3.9.7 DHHS shall provide the MCO with ninety (90) calendar days of notice of any additions or modifications to the measures and quality measure specifications.

4.12.3.9.8 At such time as DHHS provides access to Medicare data sets to the MCO, the MCO shall integrate expanded Medicare data sets into its QAPI Plan and Care Coordination and Quality Programs, and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to Medicaid-Medicare dual Members. The MCO shall:

4.12.3.9.8.1. Collect data, and monitor and evaluate for improvements to physical health outcomes, behavioral health outcomes and psycho-social outcomes resulting from Care Coordination of the dual Members;

4.12.3.9.8.2. Include Medicare data in DHHS quality reporting; and

4.12.3.9.8.3. Sign data use Agreements and submit data management plans, as required by CMS.

4.12.3.9.9 For failure to submit required reports and quality data to DHHS, NCQA, the EQRO, and/or other DHHS-identified entities, the MCO shall be subject to liquidated damages as further described in Section 5.5.2 (Liquidated Damages).

4.12.4 Evaluation

4.12.4.1 DHHS shall, at a minimum, collect the following information, and the information specified throughout the Agreement and within Exhibit O, in order to improve the performance of the MCM program [42 CFR 438.66(c)(6)-(8)]:

4.12.4.1.1 Performance on required quality measures; and

4.12.4.1.2 The MCO's QAPI Plan.

4.12.4.2 Starting in the second year of the Term of this Agreement, the MCO shall include in its QAPI Plan a detailed report of the MCO's performance against its QAPI Plan throughout the duration of the

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preceding twelve (12) months, and how its development of the proposed, updated QAPI plan has taken those results into account. The report shall include detailed information related to:

4.12.4.2.1 Completed and ongoing quality management activities, including all delegated functions;

4.12.4.2.2 Performance trends on QAPI measures to assess performance in quality of care and quality of service (QOS) for all activities identified in the QAPI Plan;

4.12.4.2.3 An analysis of whether there have been any demonstrated improvements in the quality of care or service for all activities identified in the QAPI Plan;

4.12.4.2.4 An analysis of actions taken by the MCO based on MCO specific recommendations identified by the EQRO's Technical Report and other Quality Studies; and

4.12.4.2.5 An evaluation of the overall effectiveness of the MCO's quality management program, including an analysis of barriers and recommendations for improvement.

4.12.4.3 The annual evaluation report, developed in accordance with Exhibit O, shall be reviewed and approved by the MCO's governing body and submitted to DHHS for review [42 CFR 438.330(e)(2)].

4.12.4.4 The MCO shall establish a mechanism for periodic reporting of QAPI activities to its governing body, practitioners, Members, and appropriate MCO staff, as well as for posting on the web.

4.12.4.5 In accordance with Exhibit O, the MCO shall ensure that the findings, conclusions, recommendations, actions taken, and results of QM activity are documented and reported on a semi-annual basis to DHHS and reviewed by the appropriate individuals within the organization.

4.12.5 Accountability for Quality Improvement

4.12.5.1 External Quality Review

4.12.5.1.1 The MCO shall collaborate and cooperate fully with DHHS's EQRO in the conducting of CMS EQR activities to identify opportunities for MCO improvement [42 CFR 438.358].

4.12.5.1.2 Annually, the MCO shall undergo external independent reviews of the quality, timeliness, and access to services for Members [42 CFR 438.350].

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4.12.5.1.3 To facilitate this process, the MCO shall supply information, including but not limited to:

- 4.12.5.1.3.1. Claims data,
- 4.12.5.1.3.2. Medical records,
- 4.12.5.1.3.3. Operational process details, and
- 4.12.5.1.3.4. Source code used to calculate performance measures to the EQRO as specified by DHHS.

4.12.5.2 Auto-Assignment Algorithm

4.12.5.2.1 As indicated in Section 4.3.6 (Auto-Assignment), the auto-assignment algorithm shall, over time, reward high-performing MCOs that offer high-quality, accessible care to its Members.

4.12.5.2.2 [Amendment #5:] The measures used to determine auto-assignment ~~shall not be limited to alignment shall be aligned~~ with the priority measures assigned to the program MCM Withhold and Incentive Program MCO withhold program, as determined by DHHS.

4.12.5.3 Quality Performance Withhold

4.12.5.3.1 [Amendment #5:] As described in Section 5.4 (MCM Withhold and Incentive Program), the MCM program incorporates a withhold and incentive arrangement; the MCO's performance in the program may be assessed on the basis of the MCO's quality performance, as determined by DHHS and indicated to the MCO in annual periodic guidance.

4.12.5.3.2 [Amendment #5:] ~~Intentionally left blank. Key areas of DHHS focus in the selection of measures shall include, but are not limited to:~~

4.12.5.3.2.1. [Amendment #5:] ~~Intentionally left blank. Utilization measures, including appropriate use of the ED, reduction in preventable admissions, and/or 30-day hospital readmission for all causes;~~

4.12.5.3.2.2. [Amendment #5:] ~~Intentionally left blank. Measures related to the timeliness of prenatal and postpartum care and in improved outcomes related to NAS births;~~

4.12.5.3.2.3. [Amendment #5:] ~~Intentionally left blank. Successful integration of physical and behavioral health;~~

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~~including timeliness of a follow up after a mental illness or Substance Use Disorder inpatient or residential admission;~~

4.12.5.3.2.4. [Amendment #5:] Intentionally left blank.
~~Reduction in polypharmacy resulting in drug interaction harm; and~~

4.12.5.3.2.5. [Amendment #5:] Intentionally left blank.
~~Certain clinical and non-clinical quality measures for which there is ample opportunity for improved MCO performance.~~

4.13 Network Management

4.13.1 Network Requirements

4.13.1.1 The MCO shall maintain and monitor a network of appropriate Participating Providers that is:

4.13.1.1.1 Supported by written agreements; and

4.13.1.1.2 Sufficient to provide adequate access to all services covered under this Agreement for all Members, including those with LEP or disabilities. [42 CFR 438.206(b)(1)]

4.13.1.2 In developing its network, the MCO's Provider selection policies and procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].

4.13.1.3 [Amendment #8:] The MCO shall not employ or contract with Providers excluded from participation in federal health care programs [42 CFR 438.214(d)(1)]; 42 CFR 455.101; Section 1932(d)(5) of the Act.

4.13.1.4 The MCO shall not employ or contract with Providers who fail to provide Equal Access to services.

4.13.1.5 The MCO shall ensure its Participating Providers and Subcontractors meet all state and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to this Agreement. [42 CFR 438.230]

4.13.1.6 All Participating Providers shall be licensed and or certified in accordance with the laws of NH and not be under sanction or exclusion from any Medicare or Medicaid program. Participating Providers shall have a NH Medicaid identification number and unique

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National Provider Identifier (NPI) for every Provider type in accordance with 45 CFR 162, Subpart D.

4.13.1.7 The MCO shall provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Medical Conditions.

4.13.1.8 The MCO shall make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Agreement can be furnished promptly and without compromising the quality of care. [42 CFR 438.3(q)(1); 42 CFR 438.3(q)(3)]

4.13.1.9 The MCO shall permit Non-Participating IHCPs to refer an American Indian/Alaskan Native Member to a Participating Provider. [42 CFR 438.14(b)(6)]

4.13.1.10 The MCO shall implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Participating Providers were received by Members and the application of such verification processes on a regular basis. [42 CFR 438.608(a)(5)]

4.13.1.11 [Amendment #4:] When contracting with DME Providers, the MCO shall contract with and have in its network all Willing Providers in the state.

4.13.2 Provider Enrollment

4.13.2.1 The MCO shall ensure that its Participating Providers are enrolled with NH Medicaid.

4.13.2.2 The MCO shall prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by DHHS for determination of the MCO's network adequacy.

4.13.2.2.1 The report shall identify fully credentialed and contracted Providers, and prospective Participating Providers.

4.13.2.2.2 Prospective Participating Providers shall have executed letters of intent to contract with the MCO.

4.13.2.2.3 The MCO shall confirm its provider network with DHHS and post to its website no later than thirty (30) calendar days prior to the Member enrollment period.

4.13.2.3 The MCO shall not discriminate relative to the participation, reimbursement, or indemnification of any Provider who

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is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

4.13.2.4 If the MCO declines to include individual Provider or Provider groups in its network, the MCO shall give the affected Providers written notice of the reason for its decision. [42 CFR 438.12(a)(1); 42 CFR 438.214(c)]

4.13.2.5 The requirements in 42 CFR 438.12(a) shall not be construed to:

4.13.2.5.1 Require the MCO to contract with Providers beyond the number necessary to meet the needs of its Members;

4.13.2.5.2 Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

4.13.2.5.3 Preclude the MCO from establishing measures that are designed to maintain QOS and control costs and is consistent with its responsibilities to Members. [42 CFR 438.12(a)(1); 42 CFR 438.12(b)(1)-(3)]

4.13.2.6 The MCO shall ensure that Participating Providers are enrolled with DHHS Medicaid as Medicaid Providers consistent with Provider disclosure, screening and enrollment requirements. [42 CFR 438.608(b); 42 CFR 455.100-106; 42 CFR 455.400 – 470]

4.13.3 Provider Screening, Credentialing and Re-Credentialing

4.13.3.1 DHHS shall screen and enroll, and periodically revalidate all MCO Participating Providers as Medicaid Providers. [42 CFR 438.602(b)(1)].

4.13.3.2 The MCO shall rely on DHHS's NH Medicaid providers' affirmative screening in accordance with federal requirements and the current NCQA Standards and Guidelines for the credentialing and re-credentialing of licensed independent Providers and Provider groups with whom it contracts or employs and who fall within its scope of authority and action. [42 CFR 455.410; 42 CFR 438.206)(b)(6)]

4.13.3.3 The MCO shall utilize a universal provider datasource, at no charge to the provider, to reduce administrative requirements and streamline data collection during the credentialing and re-credentialing process.

4.13.3.4 The MCO shall demonstrate that its Participating Providers are credentialed, and shall comply with any additional Provider selection requirements established by DHHS. [42 CFR

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438.12(a)(2); 42 CFR 438.214(b)(1); 42 CFR 438.214(c); 42 CFR 438.214(e); 42 CFR 438.206(b)(6)]

4.13.3.5 The MCO's Provider selection policies and procedures shall include a documented process for credentialing and re-credentialing Providers who have signed contracts with the MCO. [42 CFR 438.214(b)]

4.13.3.6 The MCO shall submit for DHHS review during the Readiness Review period, policies and procedures for onboarding Participating Providers, which shall include its subcontracted entity's policies and procedures.

4.13.3.7 For Providers not currently enrolled with NH Medicaid, the MCO shall:

4.13.3.7.1 Make reasonable efforts to streamline the credentialing process in collaboration with DHHS;

4.13.3.7.2 Conduct outreach to prospective Participating Providers within ten (10) business days after the MCO receives notice of the Providers' desire to enroll with the MCO;

4.13.3.7.3 Concurrently work through MCO and DHHS contracting and credentialing processes with Providers in an effort to expedite the Providers' network status; and

4.13.3.7.4 Educate prospective Participating Providers on optional Member treatment and payment options while credentialing is underway, including:

4.13.3.7.4.1. Authorization of out-of-network services;

4.13.3.7.4.2. Single case agreements for an individual Member; and

4.13.3.7.4.3. If agreed upon by the prospective Participating Provider, an opportunity for the Provider to accept a level of risk to receive payment after affirmative credentialing is completed in exchange for the prospective Participating Provider's compliance with network requirements and practices.

4.13.3.8 The MCO shall process credentialing applications from all types of Providers within prescribed timeframes as follows:

4.13.3.8.1 For PCPs, within thirty (30) calendar days of receipt of clean and complete credentialing applications; and

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4.13.3.8.2 For specialty care Providers, within forty-five (45) calendar days of receipt of clean and complete credentialing applications;

4.13.3.8.3 For any Provider submitting new or missing information for its credentialing application, the MCO shall act upon the new or updated information within ten (10) business days.

4.13.3.9 The start time for the approval process begins when the MCO has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status.

4.13.3.10 A "clean and complete" application is an application that is signed and appropriately dated by the Provider, and includes:

4.13.3.10.1 Evidence of the Provider's NH Medicaid ID; and

4.13.3.10.2 Other applicable information to support the Provider application, including Provider explanations related to quality and clinical competence satisfactory to the MCO.

4.13.3.11 In the event the MCO does not process a Provider's clean and complete credentialing application within the timeframes set forth in this Section 4.13.3 of the Agreement, the MCO shall pay the Provider retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application, depending on the prescribed timeframe for the Provider type as defined in 4.13.3.8 above.

4.13.3.12 For each day a clean and complete application is delayed beyond the prescribed timeframes in this Agreement as determined by periodic audit of the MCO's Provider enrollment records by DHHS or its designee, the MCO shall be fined in accordance with Exhibit N (Liquidated Damages Matrix).

4.13.3.13 Nothing in this Agreement shall be construed to require the MCO to select a health care professional as a Participating Provider solely because the health care professional meets the NH Medicaid screening and credentialing verification standards, or to prevent an MCO from utilizing additional criteria in selecting the health care professionals with whom it contracts.

4.13.4 Provider Engagement

4.13.4.1 Provider Support Services

4.13.4.1.1 The MCO shall develop and make available Provider support services which include, at a minimum:

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4.13.4.1.1.1. A website with information and a dedicated contact number to assist and support Providers who are interested in becoming Participating Providers;

4.13.4.1.1.2. A dedicated contact number to MCO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday and 9:00 a.m. to 12:00 p.m. on Saturday for the purposes of answering questions related to contracting, billing and service provision.

4.13.4.1.1.3. Ability for Providers to contact the MCO regarding contracting, billing, and service provisions;

4.13.4.1.1.4. Training specific to integration of physical and behavioral health, person-centered Care Management, social determinants of health, and quality;

4.13.4.1.1.5. Training curriculum, to be developed, in coordination with DHHS, that addresses clinical components necessary to meet the needs of Children with Special Health Care Needs. Examples of clinical topics shall include: federal requirements for EPSDT; unique needs of Children with Special Health Care Needs; family-driven, youth-guided, person-centered treatment planning and service provisions; impact of adverse childhood experiences; utilization of evidence-based practices; trauma-informed care; Recovery and resilience principles; and the value of person-centered Care Management that includes meaningful engagement of families/caregivers;

4.13.4.1.1.6. Training on billing and required documentation;

4.13.4.1.1.7. Assistance and/or guidance on identified opportunities for quality improvement;

4.13.4.1.1.8. Training to Providers in supporting and assisting Members in grievances and appeals, as noted in Section 4.5.1 (General Requirements); and

4.13.4.1.1.9. Training to Providers in MCO claims submittal through the MCO Provider portal.

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4.13.4.1.2 The MCO shall establish and maintain a Provider services function to respond timely and adequately to Provider questions, comments, and inquiries.

4.13.4.1.3 As part of this function, the MCO shall operate a toll-free telephone line (Provider service line) from, at minimum, eight (8:00) am to five (5:00) pm EST, Monday through Friday, with the exception of DHHS-approved holidays. The Provider call center shall meet the following minimum standards, which may be modified by DHHS as necessary:

4.13.4.1.3.1 Call abandonment rate: fewer than five percent (5%) of all calls shall be abandoned;

4.13.4.1.3.2 Average speed of answer: eighty percent (80%) of all calls shall be answered with live voice within thirty (30) seconds;

4.13.4.1.3.3 Average speed of voicemail response: ninety percent (90%) of voicemail messages shall be responded to no later than the next business day (defined as Monday through Friday, with the exception of DHHS-approved holidays).

4.13.4.1.4 The MCO shall ensure that, after regular business hours, the Provider inquiry line is answered by an automated system with the capability to provide callers with information regarding operating hours and instructions on how to verify enrollment for a Member.

4.13.4.1.5 The MCO shall have a process in place to handle after-hours inquiries from Providers seeking a service authorization for a Member with an urgent or emergency medical or behavioral health condition.

4.13.4.1.6 The MCO shall track the use of State-selected and nationally recognized clinical Practice Guidelines for Children with Special Health Care Needs.

4.13.4.1.7 DHHS may provide additional guidelines to MCOs pertaining to evidence-based practices related to the following: Trauma-Focused Cognitive Behavioral Therapy; Trauma Informed Child-Parent Psychotherapy; Multi-systemic Therapy; Functional Family Therapy; Multi-Dimensional Treatment Foster Care; DBT; Multidimensional Family Therapy; Adolescent Community Reinforcement; and Assertive Continuing Care.

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4.13.4.1.8 The MCO shall track and trend Provider inquiries, complaints and requests for information and take systemic action as necessary and appropriate pursuant to Exhibit O.

4.13.4.2 Provider Advisory Board

4.13.4.2.1 [Amendment #8:] The MCO shall develop and facilitate an active Provider Advisory Board that is composed of a broad spectrum of Provider types. Provider representation on the Provider Advisory Board shall draw from and be reflective of Member needs and should ensure accurate and timely feedback on the MCM program, and shall include representation from at least one (1) FQHC, at least one (1) CMH Program, and at least one (1) Local Care Management Network provider, as applicable, ~~Integrated Delivery Network (IDN)~~.

4.13.4.2.2 The Provider Advisory Board should meet face-to-face or via webinar or conference call a minimum of four (4) times each Agreement year. Minutes of the Provider Advisory Board meetings shall be provided to DHHS upon request.

4.13.5 Provider Contract Requirements

4.13.5.1 General Provisions

4.13.5.1.1 The MCO's agreement with health care Providers shall:

4.13.5.1.1.1. Be in writing,

4.13.5.1.1.2. Be in compliance with applicable State and federal laws and regulations, and

4.13.5.1.1.3. Include the requirements in this Agreement.

4.13.5.1.2 The MCO shall submit all model Provider contracts to DHHS for review before execution of the Provider contracts with NH Medicaid Providers.

4.13.5.1.3 The MCO shall re-submit the model Provider contracts any time it makes substantive modifications.

4.13.5.1.4 DHHS retains the right to reject or require changes to any Provider contract.

4.13.5.1.5 In all contracts with Participating Providers, the MCO shall comply with requirements in 42 CFR 438.214 and RSA 420-J:4, which includes selection and retention of Participating Providers, credentialing and re-credentialing requirements, and non-discrimination.

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4.13.5.1.6 In all contracts with Participating Providers, the MCO shall follow a documented process for credentialing and re-credentialing of Participating Providers. [42 CFR 438.12(a)(2); 42 CFR 438.214(b)(2)]

4.13.5.1.7 The MCO's Participating Providers shall not discriminate against eligible Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, the ADA of 1990, 42 U.S.C. Section 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

4.13.5.1.8 The MCO shall require Participating Providers and Subcontractors to not discriminate against eligible persons or Members on the basis of their health or behavioral health history, health or behavioral health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4.13.5.1.9 The MCO shall keep participating physicians and other Participating Providers informed and engaged in the QAPI program and related activities, as described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

4.13.5.1.10 The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.14 (Alternative Payment Models).

4.13.5.1.11 The MCO may execute Participating Provider agreements, pending the outcome of screening and enrollment in NH Medicaid, of up to one hundred and twenty (120) calendar days duration but shall terminate a Participating Provider immediately upon notification from DHHS that the Participating Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without enrollment of the Provider, and notify affected Members. [42 CFR 438.602(b)(2)]

4.13.5.1.12 The MCO shall maintain a Provider relations presence in NH, as approved by DHHS.

4.13.5.1.13 The MCO shall prepare and issue Provider Manual(s) upon request to all newly contracted and credentialed Providers and

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all Participating Providers, including any necessary specialty manuals (e.g., behavioral health).

4.13.5.1.13.1. The Provider manual shall be available and easily accessible on the web and updated no less than annually.

4.13.5.1.14 The MCO shall provide training to all Participating Providers and their staff regarding the requirements of this Agreement, including the grievance and appeal system.

4.13.5.1.14.1. The MCO's Provider training shall be completed within thirty (30) calendar days of entering into a contract with a Provider.

4.13.5.1.14.2. The MCO shall provide ongoing training to new and existing Providers as required by the MCO, or as required by DHHS.

4.13.5.1.15 Provider materials shall comply with State and federal laws and DHHS and NHID requirements.

4.13.5.1.16 The MCO shall submit any Provider Manual(s) and Provider training materials to DHHS for review during the Readiness Review period and sixty (60) calendar days prior to any substantive revisions.

4.13.5.1.17 Any revisions required by DHHS shall be provided to the MCO within thirty (30) calendar days.

4.13.5.1.18 The MCO Provider Manual shall consist of, at a minimum:

4.13.5.1.18.1. A description of the MCO's enrollment and credentialing process;

4.13.5.1.18.2. How to access MCO Provider relations assistance;

4.13.5.1.18.3. A description of the MCO's medical management and Case Management programs;

4.13.5.1.18.4. Detail on the MCO's Prior Authorization processes;

4.13.5.1.18.5. A description of the Covered Services and Benefits for Members, including EPSDT and pharmacy;

4.13.5.1.18.6. A description of Emergency Services coverage;

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4.13.5.1.18.7. Member parity;

4.13.5.1.18.8. The MCO Payment policies and processes; and

4.13.5.1.18.9. The MCO Member and Provider Grievance System.

4.13.5.1.19 The MCO shall require that Providers not bill Members for Covered Services any amount greater than the Medicaid cost-sharing owed by the Member (i.e., no balance billing by Providers). [Section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230(c)(1)-(2)]

4.13.5.1.20 In all contracts with Participating Providers, the MCO shall require Participating Providers to remain neutral when assisting potential Members and Members with enrollment decisions.

4.13.5.2 Compliance with MCO Policies and Procedures

4.13.5.2.1 The MCO shall require Participating Providers to comply with all MCO policies and procedures, including without limitation:

4.13.5.2.1.1. The MCO's DRA policy;

4.13.5.2.1.2. The Provider Manual;

4.13.5.2.1.3. The MCO's Compliance Program;

4.13.5.2.1.4. The MCO's Grievance and Appeals and Provider Appeal Processes;

4.13.5.2.1.5. Clean Claims and Prompt Payment requirements;

4.13.5.2.1.6. ADA requirements;

4.13.5.2.1.7. Clinical Practice Guidelines; and

4.13.5.2.1.8. Prior Authorization requirements.

4.13.5.3 The MCO shall inform Participating Providers, at the time they enter into a contract with the MCO, about the following requirements, as described in Section 4.5 (Member Grievances and Appeals), of:

4.13.5.3.1 Member grievance, appeal, and fair hearing procedures and timeframes;

4.13.5.3.2 The Member's right to file grievances and appeals and the requirements and timeframe for filing;

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4.13.5.3.3 The availability of assistance to the Member with filing grievances and appeals; [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(A)-(C)]

4.13.5.3.4 The Member's right to request a State fair hearing after the MCO has made a determination on a Member's appeal which is adverse to the Member; and [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(D)]

4.13.5.3.5 The Member's right to request continuation of benefits that the MCO seeks to reduce or terminate during an appeal of State fair hearing filing, if filed within the permissible timeframes, although the Member may be liable for the cost of any continued benefits while the appeal or State fair hearing is pending if the final decision is adverse to the Member. [42 CFR 438.414; 42 CFR 438.10(g)(2)(xi)(E)]

4.13.5.4 Member Hold Harmless

4.13.5.4.1 The Provider shall agree to hold the Member harmless for the costs of Medically Necessary Covered Services except for applicable cost sharing and patient liability amounts indicated by DHHS in this Agreement [RSA 420-J:8.1.(a)]

4.13.5.5 Requirement to Return Overpayment

4.13.5.5.1 The Provider shall comply with the Affordable Care Act and the MCO's policies and procedures that require the Provider to report and return any Overpayments identified within sixty (60) calendar days from the date the Overpayment is identified, and to notify the MCO in writing of the reason for the Overpayment. [42 CFR 438.608(d)(2)]

4.13.5.5.2 Overpayments that are not returned within sixty (60) calendar days from the date the Overpayment was identified may be a violation of State or federal law.

4.13.5.6 Background Screening

4.13.5.6.1 The Provider shall screen its staff prior to contracting with the MCO and monthly thereafter against the Exclusion Lists.

4.13.5.6.1.1. In the event the Provider identifies that any of its staff is listed on any of the Exclusion Lists, the Provider shall notify the MCO within three (3) business days of learning of that such staff Member is listed on any of the Exclusion Lists and immediately remove such person from providing services under the agreement with the MCO.

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4.13.5.7 Books and Records Access

4.13.5.7.1 The Provider shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the Members as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements.

4.13.5.7.2 The Provider shall make available, for the purposes of an audit, evaluation, or inspection by the MCO, DHHS, MFCU, DOJ, the OIG, and the Comptroller General or their respective designees:

4.13.5.7.3 Its premises,

4.13.5.7.4 Physical facilities,

4.13.5.7.5 Equipment,

4.13.5.7.6 Books,

4.13.5.7.7 Records,

4.13.5.7.8 Contracts, and

4.13.5.7.9 Computer, or other electronic systems relating to its Medicaid Members.

4.13.5.7.10 These records, books, documents, etc., shall be available for any authorized State or federal agency, including but not limited to the MCO, DHHS, MFCU, DOJ, and the OIG or their respective designees, ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

4.13.5.8 Continuity of Care

4.13.5.8.1 The MCO shall require that all Participating Providers comply with MCO and State policies related to transition of care policies set forth by DHHS and included in the DHHS model Member Handbook.

4.13.5.9 Anti-Gag Clause

4.13.5.9.1 The MCO shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient:

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4.13.5.9.1.1. For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

4.13.5.9.1.2. For any information the Member needs in order to decide among all relevant treatment options;

4.13.5.9.1.3. For the risks, benefits, and consequences of treatment or non-treatment; or

4.13.5.9.1.4. For the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. [Section 1923(b)(3)(D) of the Social Security Act; 42 CFR 438.102(a)(1)(i)-(iv); SMDL 2/20/98]

4.13.5.9.2 The MCO shall not take punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, consistent with the requirements in Section 4.5.5 (Expedited Appeal). [42 CFR 438.410(b)]

4.13.5.10 Anti-Discrimination

4.13.5.10.1 The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification or against any Provider that serves high-risk populations or specializes in conditions that require costly treatment.

4.13.5.10.2 This paragraph shall not be construed to prohibit an organization from:

4.13.5.10.2.1. Including Providers only to the extent necessary to meet the needs of the organization's Members,

4.13.5.10.2.2. Establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or

4.13.5.10.2.3. Using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

4.13.5.10.3 If the MCO declines to include individual or groups of Providers in its network, it shall give the affected Providers written notice of the reason for the decision.

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4.13.5.10.4 In all contracts with Participating Providers, the MCO's Provider selection policies and procedures shall not discriminate against particular Providers that service high-risk populations or specialize in conditions that require costly treatment. [42 CFR 438.12(a)(2); 42 CFR 438.214(c)]

4.13.5.11 Access and Availability

4.13.5.11.1 The MCO shall ensure that Providers comply with the time and distance and wait standards, including but not limited to those described in Section 4.7.3 (Time and Distance Standards) and Section 4.7.3.4 (Additional Provider Standards).

4.13.5.12 Payment Models

4.13.5.12.1 The MCO shall negotiate rates with Providers in accordance with Section 4.14 (Alternative Payment Models) and Section 4.15 (Provider Payments) of this Agreement, unless otherwise specified by DHHS (e.g., for Substance Use Disorder Provider rates).

4.13.5.12.2 The MCO Provider contract shall contain full and timely disclosure of the method and amount of compensation, payments, or other consideration, to be made to and received by the Provider from the MCO, including for Providers paid by an MCO Subcontractor, such as the PBM.

4.13.5.12.3 The MCO Provider contract shall detail how the MCO shall meet its reporting obligations to Providers as described within this Agreement.

4.13.5.13 Non-Exclusivity

4.13.5.13.1 The MCO shall not require a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.

4.13.5.14 Proof of Membership

4.13.5.14.1 The MCO Provider contract shall require Providers in the MCO network to accept the Member's Medicaid identification card as proof of enrollment in the MCO until the Member receives his/her MCO identification card.

4.13.5.15 Other Provisions

4.13.5.15.1 The MCO's Provider contract shall also contain:

4.13.5.15.1.1. All required activities and obligations of the Provider and related reporting responsibilities.

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4.13.5.15.1.2. Requirements to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and applicable provisions of this Agreement.

4.13.5.15.1.3. A requirement to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority.

4.13.6 Reporting

4.13.6.1 The MCO shall comply with and complete all reporting in accordance with Exhibit O, this Agreement, and as further specified by DHHS.

4.13.6.2 The MCO shall implement and maintain arrangements or procedures for notification to DHHS when it receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the managed care program, including the termination of the Provider agreement with the MCO. [42 CFR 438.608(a)(4)]

4.13.6.3 The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the Participating Provider network.

4.13.6.4 As part of the notice, the MCO shall submit a Transition Plan to DHHS to address continued Member access to needed service and how the MCO shall maintain compliance with its contractual obligations for Member access to needed services.

4.13.6.5 A significant change is defined as:

4.13.6.5.1 A decrease in the total number of PCPs by more than five percent (5%);

4.13.6.5.2 A loss of all Providers in a specific specialty where another Provider in that specialty is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement;

4.13.6.5.3 A loss of a hospital in an area where another contracted hospital of equal service ability is not available within time and distance standards outlined in Section 4.7.3 (Time and Distance Standards) of this Agreement; and/or

4.13.6.5.4 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to Participating Providers.

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4.13.6.6 The MCO shall provide to DHHS and/or its DHHS Subcontractors (e.g., the EQRO) Provider participation reports on an annual basis or as otherwise determined by DHHS in accordance with Exhibit O; these may include but are not limited to Provider participation by geographic location, categories of service, Provider type categories, Providers with open panels, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze Provider service capacity in terms of Member access to health care.

4.14 Alternative Payment Models

4.14.1 As required by the special terms and conditions of The NH Building Capacity for Transformation waiver, NH is implementing a strategy to expand use of APMs that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to DHHS, Providers, and the stakeholder community.

4.14.2 In developing and refining its APM strategy, DHHS relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the "HCP-LAN APM framework") in order to:

4.14.2.1 Clearly and effectively communicate DHHS requirements through use of the defined categories established by HCP-LAN;

4.14.2.2 Encourage the MCO to align MCM APM offerings to other payers' APM initiatives to minimize Provider burden; and

4.14.2.3 Provide an established framework for monitoring MCO performance on APMs.

4.14.3 Prior to and/or over the course of the Term of this Agreement, DHHS shall develop the DHHS Medicaid APM Strategy, which may result in additional guidance, templates, worksheets and other materials that elucidate the requirements to which the MCO is subject under this Agreement.

4.14.4 Within the guidance parameters established and issued by DHHS and subject to DHHS approval, the MCO shall have flexibility to design Qualifying APMs (as defined in Section 4.14 of this Agreement) consistent with the DHHS Medicaid APM strategy and in conformance with CMS guidance.

4.14.5 The MCO shall support DHHS in developing the DHHS Medicaid APM Strategy through participation in stakeholder meetings and planning efforts, providing all required and otherwise requested information related to APMs, sharing data and analysis, and other activities as specified by DHHS.

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4.14.6 For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and DHHS shall ensure that it:

4.14.6.1 Makes participation in the APM available, using the same terms of performance, to a class of Providers providing services under the contract related to the reform or improvement initiative;

4.14.6.2 Uses a common set of performance measures across all the Providers;

4.14.6.3 Does not set the amount or frequency of the expenditures; and

4.14.6.4 Does not permit DHHS to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

4.14.7 Required Use of Alternative Payment Models Consistent with the New Hampshire Building Capacity for Transformation Waiver

4.14.7.1 Consistent with the requirements set forth in the special terms and conditions of NH's Building Capacity for Transformation waiver, the MCO shall ensure through its APM Implementation Plan (as described in Section 4.14) that fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs, as defined by DHHS, within the first twelve (12) months of this Agreement, subject to the following exceptions:

4.14.7.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have eighteen (18) months to meet this requirement; and

4.14.7.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS.

4.14.7.1.2.1. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6) months after the initial 18 month period.

4.14.7.1.2.2. For failure to meet this requirement, DHHS reserves the right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N, Section 3.2 (Liquidated Damages Matrix).

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4.14.7.2 MCO Incentives and Penalties for APM Implementation

4.14.7.2.1 Consistent with RSA 126-AA, the MCO shall include, through APMs and other means, Provider alignment incentives to leverage the combined DHHS, MCO, and providers to achieve the purpose of the incentives.

4.14.7.2.2 MCOs shall be subject to incentives, at DHHS' sole discretion, and/or penalties to achieve improved performance, including preferential auto-assignment of new members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

4.14.8 Qualifying Alternative Payment Models

4.14.8.1 A Qualifying APM is a payment approach approved by DHHS as consistent with the standards specified in this Section 4.14.8 (Qualifying Alternative Payment Models) and the DHHS Medicaid APM Strategy.

4.14.8.2 [Amendment #5:] At minimum, a Qualifying APM shall meet the requirements of the HCP-LAN APM framework Category 2B 2G, based on the refreshed 2017 framework released on July 11, 2017 and all subsequent revisions.

4.14.8.3 [Amendment #5:] As indicated in the HCP-LAN APM framework white paper, Category 2B 2G is met if the payment arrangement between the MCO and Participating Provider(s) rewards Participating Providers at a minimum for reporting quality metrics that perform well on quality metrics and/or penalizes Participating Providers that do not perform well on these metrics.

4.14.8.4 [Amendment #5:] HCP-LAN Categories 2B, 3A, 3B, 4A, 4B, and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy.

4.14.8.5 DHHS shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.14.10.2 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to DHHS, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.

4.14.8.6 Under no circumstances shall DHHS consider a payment methodology that takes cost of care into account without also considering quality a Qualifying APM.

4.14.8.7 Standards for Large Providers and Provider Systems

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4.14.8.7.1 The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the DHHS Medicaid APM Strategy.

4.14.8.8 Treatment of Payments to Community Mental Health Programs

4.14.8.8.1 The CMH Program payment model prescribed by DHHS in Section 4.11.5.1 (Contracting for Community Mental Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.8.2 At the sole discretion of DHHS, additional payment models specifically required by and defined as an APM by DHHS shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.9 [Amendment #5:] Accommodations for Other Providers Small Providers

4.14.8.9.1 [Amendment #5:] The MCO ~~may~~ shall develop Qualifying APM models appropriate for small Providers, and/or Federally Qualified Health Centers (FQHCs), as further defined by the DHHS Medicaid APM Strategy.

4.14.8.9.2 For example, the MCO may propose to DHHS models that incorporate pay-for-performance bonus incentives and/or per Member per month payments related to Providers' success in meeting actuarially-relevant cost and quality targets.

4.14.8.10 Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health

4.14.8.10.1 The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden and promote the integration of Behavioral Health.

4.14.8.10.2 [Amendment #5:] The MCO ~~shall~~ may incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Payer Advanced APM" (including but not limited to a Medicaid Medical Home Model) under the requirements of the Quality Payment Program as set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

4.14.9 MCO Alternative Payment Model Implementation Plan

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4.14.9.1 The MCO shall submit to DHHS for review and approval an APM Implementation Plan in accordance with Exhibit O.

4.14.9.2 The APM Implementation Plan shall meet the requirements of this section and of any subsequent guidance issued as part of the DHHS Medicaid APM Strategy.

4.14.9.3 Additional details on the timing, format, and required contents of the MCO APM Implementation Plan shall be specified by DHHS in Exhibit O and/or through additional guidance.

4.14.9.4 Alternative Payment Model Transparency

4.14.9.4.1 The MCO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the MCO's methodology, as well as the basis for developing and assessing Participating Provider performance in the APM, as described in Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how integration is promoted by the model among the MCO, Providers, and Members.

4.14.9.5 Provider Engagement and Support

4.14.9.5.1 The APM Implementation Plan shall describe a logical and reasonably achievable approach to implementing APMs, supported by an understanding of NH Medicaid Providers' readiness for participation in APMs, and the strategies the MCO shall use to assess and advance such readiness over time.

4.14.9.5.2 The APM Implementation Plan shall outline in detail what strategies the MCO plans to use, such as, meetings with Providers and IDNs, as appropriate, and the frequency of such meetings, the provision of technical support, and a data sharing strategy for Providers reflecting the transparency, reporting and data sharing obligations herein and in the DHHS Medicaid APM Strategy.

4.14.9.5.3 The MCO APM Implementation Plan shall ensure Providers and IDNs, as appropriate, are supported by data sharing and performance analytic feedback systems and tools that make actuarially sound and actionable provider level and system level clinical, cost, and performance data available to Providers in a timely manner for purposes of developing APMs and analyzing performance and payments pursuant to APMs.

4.14.9.5.4 MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

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4.14.9.6 Implementation Approach

4.14.9.6.1 The MCO shall include in the APM Implementation Plan a detailed description of the steps the MCO shall take to advance its APM Implementation Plan:

- 4.14.9.6.1.1. In advance of the Program Start Date;
- 4.14.9.6.1.2. During the first year of this Agreement; and
- 4.14.9.6.1.3. Into the second year and beyond, clearly articulating its long-term vision and goals for the advancement of APMs over time.

4.14.9.6.2 The APM Implementation Plan shall include the MCO's plan for providing the necessary data and information to participating APM Providers to ensure Providers' ability to successfully implement and meet the performance expectations included in the APM, including how the MCO shall ensure that the information received by Participating Providers is meaningful and actionable.

4.14.9.6.3 The MCO shall provide data to Providers and IDNs, as appropriate, that describe the retrospective cost and utilization patterns for Members, which shall inform the strategy and design of APMs.

4.14.9.6.4 For each APM entered into, the MCO shall provide timely and actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM.

4.14.9.6.5 In addition, the MCO shall provide Member and Provider level data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions.

4.14.9.6.6 The APM Implementation Plan shall describe in example form to DHHS the level of information that shall be given to Providers that enter into APM Agreements with the MCO, including if the level of information shall vary based on the Category and/or type of APM the Provider enters.

4.14.9.6.7 The information provided shall be consistent with the requirements outlined under Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The MCOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

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4.14.10 Alternative Payment Model Transparency and Reporting Requirements

4.14.10.1 Transparency

4.14.10.1.1 In the MCO APM Implementation Plan, the MCO shall provide to DHHS for each APM, as applicable, the following information at a minimum:

4.14.10.1.1.1. The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.14.10.1.1.2. The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, the attachment points for cost targets, and risk adjustment methodology;

4.14.10.1.1.3. The approach to determining quality benchmarks and evaluating Provider performance, including advance communication of the specific measures that shall be used to determine quality performance, the methodology for calculating and assessing Provider performance, and any quality gating criteria that may be included in the APM design; and

4.14.10.1.1.4. The frequency at which the MCO shall regularly report cost and quality data related to APM performance to Providers, and the information that shall be included in each report.

4.14.10.1.2 Additional information may be required by DHHS in supplemental guidance. All information provided to DHHS shall be made available to Providers eligible to participate in or already participating in the APM unless the MCO requests and receives DHHS approval for specified information not to be made available.

4.14.10.2 Standardized Assessment of Alternative Payment Model Usage

4.14.10.2.1 The MCO shall complete, attest to the contents of, and submit to DHHS the HCP-LAN APM assessment²⁷ in accordance with Exhibit O.

²⁷ The MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).

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4.14.10.2.2 Thereafter, the MCO shall complete, attest to the contents of, and submit to DHHS the HCP-LAN APM assessment in accordance with Exhibit O and/or the DHHS Medicaid APM Strategy.

4.14.10.2.3 If the MCO reaches an agreement with DHHS that its implementation of the required APM model(s) may be delayed, the MCO shall comply with all terms set forth by DHHS for the additional and/or alternative timing of the MCO's submission of the HCP-LAN APM assessment.

4.14.10.3 Additional Reporting on Alternative Payment Model Outcomes

4.14.10.3.1 The MCO shall provide additional information required by DHHS in Exhibit O or other DHHS guidance on the type, usage, effectiveness and outcomes of its APMs.

4.14.11 Development Period for MCO Implementation

4.14.11.1 Consistent with the requirements for new MCOs, outlined in Section 4.14.8 (Qualifying Alternative Payment Models) above, DHHS acknowledges that MCOs may require time to advance their MCO Implementation Plan. DHHS shall provide additional detail, in its Medicaid APM Strategy, that describes how MCOs should expect to advance use of APMs over time.

4.14.12 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters

4.14.12.1 [Amendment #5:] The MCO's APM Implementation Plan shall indicate the quantitative, measurable clinical outcomes the MCO seeks to improve through its APM and QAPI initiative(s).

4.14.12.2 At a minimum, the MCO shall address the priorities identified in this Section 4.14.12 (Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters) and all additional priorities identified by DHHS in the DHHS Medicaid APM Strategy.

4.14.12.3 State Priorities in RSA 126-AA

4.14.12.3.1 [Amendment #5:] The MCO's APM Implementation Plan and/or QAPI Plan shall address the following priorities:

4.14.12.3.1.1. Opportunities to decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;

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4.14.12.3.1.2. Opportunities to reduce preventable admissions and thirty (30)-day hospital readmission for all causes;

4.14.12.3.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of NAS births;

4.14.12.3.1.4. Opportunities to better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with IDNs to advance the goals of the Building Capacity for Transformation waiver;

4.14.12.3.1.5. Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing generic prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing polypharmacy, as described in Section 4.2.5 (Medication Management);

4.14.12.3.1.6. Opportunities to enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.5 (Payment to Substance Use Disorder Providers) of this Agreement); and

4.14.12.3.1.7. Opportunities to address social determinants of health (further addressed in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address "ED boarding," in which Members that would be best treated in the community remain in the ED.

4.14.12.4 Alternative Payment Models for Substance Use Disorder Treatment

4.14.12.4.1 As is further described in Section 4.11.6.5 (Payment to Substance Use Disorder Providers), the MCO shall include in its APM Implementation Plan:

4.14.12.4.1.1. At least one (1) APM that promotes the coordinated and cost-effective delivery of high-quality care to infants born with NAS; and

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4.14.12.4.1.2. At least one (1) APM that promotes greater use of Medication-Assisted Treatment.

4.14.12.5 Emerging State Medicaid and Public Health Priorities

4.14.12.5.1 The MCO shall address any additional priorities identified by DHHS in the Medicaid APM Plan or related guidance.

4.14.12.5.2 If DHHS adds or modifies priorities after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of its APM Implementation Plan.

4.14.13 Physician Incentive Plans

4.14.13.1 The MCO shall submit all Physician Incentive Plans to DHHS for review as part of its APM Implementation Plan or upon development of Physician Incentive Plans that are separate from the MCO's APM Implementation Plan.

4.14.13.2 The MCO shall not implement Physician Incentive Plans until they have been reviewed and approved by DHHS.

4.14.13.3 Any Physician Incentive Plan, including those detailed within the MCO's APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to "MA organization," "CMS," and "Medicare beneficiaries" should be read as references to "MCO," "DHHS," and "Members," respectively. These include that:

4.14.13.3.1 The MCO may only operate a Physician Incentive Plan if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or Physician Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.14.13.3.2 If the MCO puts a physician or Physician Group at substantial financial risk for services not provided by the physician or Physician Group, the MCO shall ensure that the physician or Physician Group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(2); 42 CFR 438.3(i)]

4.14.13.4 The MCO shall submit to DHHS annually, at the time of its annual HCP-LAN assessment, a detailed written report of any implemented (and previously reviewed) Physician Incentive Plans, as described in Exhibit O.

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4.14.13.5 Annual Physician Incentive Plan reports shall provide assurance satisfactory to DHHS that the requirements of 42 CFR 438.208 are met. The MCO shall, upon request, provide additional detail in response to any DHHS request to understand the terms of Provider payment arrangements.

4.14.13.6 The MCO shall provide to Members upon request the following information:

4.14.13.6.1 Whether the MCO uses a Physician Incentive Plan that affects the use of referral services;

4.14.13.6.2 The type of incentive arrangement; and

4.14.13.6.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)].

4.15 Provider Payments

4.15.1 General Requirements

4.15.1.1 The MCO shall not, directly or indirectly, make payment to a physician or Physician Group or to any other Provider as an inducement to reduce or limit Medically Necessary Services furnished to a Member. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 438.3(i)]

4.15.1.2 The MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) [Section 1903 of the Social Security Act]:

4.15.1.2.1 Furnished under the MCO by an individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.

4.15.1.2.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act when the person knew or had any reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

4.15.1.2.3 Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the

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individual or entity, unless the State determines there is good cause not to suspend such payments.

4.15.1.2.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

4.15.1.2.5 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. [Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(2)(A) - (C) of the Social Security Act; section 1903(i)(16) - (17) of the Social Security Act]

4.15.1.3 No payment shall be made to a Participating Provider other than by the MCO for services covered under the Agreement between DHHS and the MCO, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR, or when DHHS makes direct payments to Participating Providers for graduate medical education costs approved under the Medicaid State Plan, or have been otherwise approved by CMS. [42 CFR 438.60]

4.15.1.4 The MCO shall reimburse Providers based on the Current Procedural Terminology (CPT) code's effective date. To the extent a procedure is required to be reimbursed under the Medicaid State Plan but no CPT code or other billing code has been provided by DHHS, the MCO shall contact DHHS and obtain a CPT code and shall retroactively reimburse claims based on the CPT effective date as a result of the CPT annual updates.

4.15.1.4.1 [Amendment #2:] For MCO provider contracts based on NH Medicaid fee schedules, the MCO shall reimburse providers for annual and periodic fee schedule adjustments in accordance with their effective dates.

4.15.1.5 The MCO shall permit Providers up to one hundred and twenty (120) calendar days to submit a timely claim. The MCO shall establish reasonable policies that allow for good cause exceptions to the one hundred and twenty (120) calendar day timeframe.

4.15.1.6 Good cause exceptions shall accommodate foreseeable and unforeseeable events such as:

4.15.1.6.1 A Member providing the wrong Medicaid identification number,

4.15.1.6.2 Natural disasters; or

4.15.1.6.3 Failed information technology systems.

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4.15.1.7 The Provider should be provided a reasonable opportunity to rectify the error, once identified, and to either file or re-file the claim.

4.15.1.8 Within the first one hundred and eighty (180) calendar days of the Program Start Date, DHHS has discretion to direct MCOs to extend the one hundred and twenty (120) calendar days on case by case basis.

4.15.1.9 The MCO shall pay interest on any Clean Claims that are not paid within thirty (30) calendar days at the interest rate published in the Federal Register in January of each year for the Medicare program.

4.15.1.10 The MCO shall collect data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and Care Coordination efforts. [42 CFR 438.242(b)(3)(iii)]

4.15.1.11 The MCO shall implement and maintain arrangements or procedures for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud, to DHHS. [42 CFR 438.608(a)(2)]

4.15.2 Hospital-Acquired Conditions and Provider-Preventable Conditions

4.15.2.1 The MCO shall comply with State and federal laws requiring nonpayment to a Participating Provider for Hospital-Acquired Conditions and for Provider-Preventable Conditions.

4.15.2.2 The MCO shall not make payments to a Provider for a Provider-Preventable Condition that meets the following criteria:

4.15.2.2.1 Is identified in the Medicaid State Plan;

4.15.2.2.2 Has been found by NH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

4.15.2.2.3 Has a negative consequence for the Member;

4.15.2.2.4 Is auditable; and

4.15.2.2.5 Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.3(g); 42 CFR 438.6(a)(12)(i); 42 CFR 447.26(b)]

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4.15.2.3 The MCO shall require all Providers to report Provider-Preventable Conditions associated with claims for payment or Member treatments for which payment would otherwise be made, in accordance with Exhibit O. [42 CFR 438.3(g); 42 CFR 434.6(a)(12)(ii); 42 CFR 447.26(d)]

4.15.3 Federally Qualified Health Centers and Rural Health Clinics

4.15.3.1 FQHCs and RHCs shall be paid at minimum the encounter rate paid by DHHS at the time of service, and shall also be paid for DHHS-specified CPT codes outside of the encounter rates.

4.15.3.2 The MCO shall not provide payment to an FQHC or RHC that is less than the level and amount of payment which the MCO would make for the services if the services were furnished by a Provider which is not an FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Social Security Act]

4.15.3.3 [Amendment #5:] The MCO may shall enter into Alternative Payment Models with FQHCs, RHCs, and/or other health or family planning clinics or their designated contracting organizations as negotiated and agreed upon with DHHS in the MCO's APM Implementation Plan and as described by DHHS in the Medicaid APM Strategy.

4.15.4 Hospice Payment Rates

4.15.4.1 The Medicaid hospice payment rates shall be calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services.

4.15.5 Community Mental Health Programs

4.15.5.1 The MCO shall, as described in Section 4.11.5.2 (Payment to Community Mental Health Programs and Community Mental Health Providers), meet the specific payment arrangement criteria in contracts with CMH Programs and CMH Providers for services provided to Members.

4.15.5.2 [Amendment #3:] Subject to CMH Provider Agreement modification, the MCO shall waive its CMH Program contracted minimum Maintenance of Effort (MOE) requirements for the purpose of providing COVID-19 Public Health Emergency fiscal relief during the SFY 2020 period.

4.15.5.2.1 [Amendment #9:] "Maintenance of effort" (MOE), defined in the payer/provider contract for a specified period of time,

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commonly refers to minimum performance requirements which the provider must achieve to earn or retain all or a portion of the provider's capitated payments either through reimbursement withheld by the payer or adjusted after reconciliation and settlement of the provider's payment(s) for the period.

4.15.5.3 [Amendment #3:] Such MOE waiver described in Section 4.15.5.2 shall not inadvertently cause reductions in the MCO's CMH Program contracted capitation rates in future rating periods.

4.15.5.4 [Amendment #5]: The MCO shall not extend the MOE relief waiver described in Sections 4.15.5.2 and 4.15.5.3 beyond March 31, 2021, unless a Public Health Emergency is extended beyond the 31st in which case the MOE relief shall nonetheless end on June 30, 2021.

4.15.5.4.1 [Amendment #10:] [Amendment #8:] The MCO shall limit any MOE clawback that is determined to fifty percent (50%) for the period July 1, 2023 2022 through August 31, 2024 ~~December 31, 2022~~; and limit MOE clawback to seventy percent (70%) for the period January 1, 2023 through June 30, 2023.

4.15.5.4.1.1. [Amendment #8:] The MCO shall include in their contracts with CMHCs, the following:

4.15.5.4.1.1.1 [Amendment #8:] Utilization of MOE thresholds in place for the SFY 2021 fiscal period.

4.15.5.4.1.1.2 [Amendment #8:] CMHC requirements to explicitly reserve for MOE liability for failure to meet the threshold.

4.15.5.4.1.1.3 [Amendment #8:] Agreement the MCO shall clawback no more than fifty percent (50%) of any individual CMHC's MOE liability/reserve after the year end reconciliation is complete following two months of runout for SFY 2022.

4.15.5.4.1.1.4 [Amendment #8:] Requirements the CMHCs shall contractually commit to applying its portion of any "retained reserve account" to workforce and provide a detailed accounting to the Department.

4.15.5.4.1.1.5 [Amendment #8:] The MCO's clawback shall be calculated as a part of the Medical

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Loss Ratio provisions in the MCO's Agreement with DHHS.

4.15.5.4.1.1.6 [Amendment #8:] Should there be materiality of substituted services by non-CMHC Providers determined by the Department's actuary due to MOE adherence, the actuarial value and materiality of partial hospitalization services shall be acknowledged as such with a contractual adjustment.

4.15.5.5 [Amendment #6:] The MCO shall remit directed payment(s) to eligible Community Mental Health Programs (CMHPs) in accordance with separate guidance, as follows:

4.15.5.5.1 [Amendment #6:] For the rating period September 1, 2019 through June 30, 2020 directed payment amounts determined by DHHS shall comprise uniform dollar or percentage increases for Community Mental Health Programs for Assertive Community Treatment, Mobile Crisis Services, Same Day Access upon New Hampshire Hospital Discharge, and Step Down Community Residence Beds, as approved by CMS.

4.15.5.5.2 [Amendment #6:] For the rating period July 1, 2020 through June 30, 2021, directed payment amounts determined by DHHS shall comprise a uniform dollar increase for assertive community treatment services, mobile crisis response services, specialty residential services, same day/next day access upon hospital/designated receiving facility discharges, and step down community residence beds for individuals dually diagnosed with serious mental illness and development disabilities, as approved by CMS.

4.15.5.5.3 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment amounts determined by DHHS shall comprise a fee schedule adjustment or uniform dollar increase for assertive community treatment, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, consistent illness management and recovery services, and step down community residence beds for individuals dually diagnosed with serious mental illness and developmental disabilities, within the Community Mental Health Programs class of network providers as approved by CMS, including any alternate CMS-approved directed payment methodology.

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4.15.5.5.4 [Amendment #10:] [Amendment #8:] For the rating period July 1, 2023 2022 through August 31, 2024June 30, 2023, directed payment amounts determined by DHHS shall comprise a fee schedule adjustment or uniform dollar increase for assertive community treatment, same day/next day and weekly access upon New Hampshire Hospital/designated receiving facility discharges, timely prescriber referral after intake, consistent illness management and recovery services, and step down community residence beds for individuals dually diagnosed with serious mental illness and developmental disabilities, within the Community Mental Health Programs class of network providers as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.5.6 [Amendment #7:] [Amendment #6:] The MCO shall reimburse remit directed payment(s) to eligible Community Mental Health Programs (CMHPs) for Community Residential Services, as follows:

4.15.5.6.1 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise a minimum fee schedule at least at the FFS rates established by DHHS for Community Residential Services.

4.15.5.6.2 [Amendment #10:] [Amendment #8:] For the rating period July 1, 2023 2022 through August 31, 2024June 30, 2023, directed payment remittance shall comprise a minimum fee schedule at least at the FFS rates established by DHHS for Community Residential Services.

4.15.6 Payment Standards for Substance Use Disorder Providers

4.15.6.1 The MCO shall, as described in Section 4.11.6 (Substance Use Disorder), reimburse Substance Use Providers as directed by DHHS.

4.15.7 Payment Standards for Private Duty Nursing Services

4.15.7.1 The MCO shall reimburse private duty nursing agencies for private duty nursing services at least at the FFS rates established by DHHS.

4.15.8 Payment Standards for Indian Health Care Providers

4.15.8.1 The MCO shall pay IHCPs, whether Participating Providers or not, for Covered Services provided to American Indian Members who are eligible to receive services at a negotiated rate between the MCO and the IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the MCO

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would make for the services to a Participating Provider that is not an IHCP. [42 CFR 438.14(b)(2)(i) - (ii)]

4.15.8.2 For contracts involving IHCPs, the MCO shall meet the requirements of FFS timely payment for all I/T/U Providers in its network, including the paying of ninety-five percent (95%) of all Clean Claims within thirty (30) calendar days of the date of receipt; and paying ninety-nine percent (99%) of all Clean Claims within ninety (90) calendar days of the date of receipt. [42 CFR 438.14(b)(2)(iii); ARRA 5006(d); 42 CFR 447.45; 42 CFR 447.46; SMDL 10-001]

4.15.8.3 IHCPs enrolled in Medicaid as FQHCs but not Participating Providers of the MCO shall be paid an amount equal to the amount the MCO would pay an FQHC that is a Participating Provider but is not an IHCP, including any supplemental payment from DHHS to make up the difference between the amount the MCO pays and what the IHCPs FQHC would have received under FFS. [42 CFR 438.14(c)(1)]

4.15.8.4 When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Medicaid State Plan's FFS payment methodology. [42 CFR 438.14(c)(2)]

4.15.8.5 When the amount the IHCP receives from the MCO is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, DHHS shall make a supplemental payment to the IHCP to make up the difference between the amount the MCO pays and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 CFR 438.14(c)(3)]

4.15.9 Transition Housing Program

The MCO shall reimburse Transition Housing Program services at least at the FFS rates established by DHHS.

4.15.10 Payment Standards for DME Providers

4.15.10.1 [Amendment #6:] Beginning January 1, 2020, the MCO shall reimburse DME Providers for DME and DME related services, as follows:
~~[Base Contract:] No earlier than January 1, 2020, the MCO shall reimburse DME Providers for DME and DME related services at 80% of the FFS rates established by DHHS.~~

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4.15.10.1.1 [Amendment #6:] For the rating period September 1, 2019 through June 30, 2020, directed payment remittance shall comprise a minimum fee schedule at 80% of the DHHS FFS fee schedule, as approved by CMS.

4.15.10.1.2 [Amendment #6:] For the rating period July 1, 2020 through June 30, 2021, directed payment remittance shall comprise a minimum fee schedule at 80% of the DHHS FFS fee schedule, as approved by CMS.

4.15.10.1.3 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise a minimum fee schedule at 80% of the DHHS FFS fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.10.1.4 [Amendment #8:] For the rating period July 1, 2022 through June 30, 2023, MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.10.1.5 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, MCO provider reimbursement shall comprise payments at a minimum 80% of the DHHS FFS State Plan fee schedule as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.11 [Amendment #3:] Payment Standards for Certain Providers Affected by the COVID-19 Public Health Emergency

4.15.11.1 [Amendment #6:] The MCO shall remit directed payments related to the COVID 19 Public Health Emergency in accordance with separate guidance, as follows: [Amendment #3:] The MCO shall cooperate in implementing CMS-approved COVID-19 Public Health Emergency-related directed payments in accordance with prescribed DHHS guidance.

4.15.11.1.1 [Amendment #6:] For the rating period September 1, 2019 through June 30, 2020, directed payment amounts determined by DHHS shall comprise a uniform percent increase to defined safety net provider classes as approved by CMS.

4.15.11.2 [Amendment #7:] The MCO shall remit directed payments related to funding available through the American Rescue Plan Act of 2021 (ARPA) Section 9817, as follows:

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4.15.11.2.1 [Amendment #7:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise an additional payment calculated by DHHS at a percentage payment increase to defined Home and Community Based Service (HCBS) provider classes (e.g., private duty nursing, home care, personal care, durable medical equipment, substance use disorder residential providers, Community Mental Health Centers) for specified codes in accordance with separate guidance and as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.12 [Amendment #4:] Payment Standards for Directed Payments

4.15.12.1 [Amendment #4:] Any directed payments proposed to CMS shall be described in the program's actuarial certification for the rating period.

4.15.12.2 [Amendment #7:] The term "minimum fee schedule" in this Section 4.15, shall infer the minimum provider reimbursement amount(s) permissible under the terms of this Agreement.

4.15.13 [Amendment #6:] Critical Access Hospitals (CAHs)

4.15.13.1 [Amendment #6:] The MCO shall remit directed payment(s) to CAHs in accordance with separate guidance, as follows:

4.15.13.1.1 [Amendment #6:] For the rating period July 1, 2020 through June 30, 2021, directed payment amounts determined by DHHS shall comprise a uniform rate increase for inpatient discharges and outpatient visits to qualifying CAHs as approved by CMS.

4.15.13.1.2 [Amendment #6:] For the rating period July 1, 2021 through June 30, 2022, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.13.1.3 [Amendment #8:] For the rating period July 1, 2022 through June 30, 2023, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology.

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4.15.13.1.4 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, directed payment amounts determined by DHHS shall comprise a uniform rate increase for all inpatient discharges and outpatient encounters as approved by CMS, including any alternate CMS-approved directed payment methodology. Qualified directed payments are tied to actual hospital services, including the number of inpatient discharges and outpatient visits reported by qualifying Providers.

4.15.14 [Amendment #6:] Designated Receiving Facilities (DRFs)

4.15.14.1 [Amendment #7] [Amendment #6:] The MCO shall remit minimum directed payments to ~~DHHS approved NH~~ Medicaid enrolled DRFs as designated by the Commissioner, ~~in accordance with separate guidance~~, as follows:

4.15.14.1.1 [Amendment #7] [Amendment #6:] For the July 1, 2021 through June 30, 2022 rating period, the MCO directed payment remittance to the Peer Group 06 provider shall comprise the minimum ~~Peer Group 01 and 07, Peer Group 02, Peer Group 06, and Peer Group 09 State Plan~~ DRG fee schedule payment amounts described in Section 6.2.41.1, and the State Plan rate for Hampstead Hospital.

4.15.14.1.2 [Amendment #8:] For the July 1, 2022 through June 30, 2023 rating period, the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 State Plan DRG fee schedule payment amounts described in Section 6.2.41.1.

4.15.14.1.3 [Amendment #10:] For the July 1, 2023 through August 31, 2024 rating period, the MCO directed payment remittance to the Peer Group 06 providers shall comprise the minimum Peer Group 06 State Plan DRG fee schedule payment amounts described in Section 6.2.41.1.

4.15.15 [Amendment #7:] Neuropsychological Testing Services

4.15.15.1 [Amendment #7:] Beginning July 1, 2021, the MCO shall reimburse eligible providers for covered neuropsychological testing services, as follows:

4.15.15.1.1 [Amendment #7:] For the rating period July 1, 2021 through June 30, 2022, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

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4.15.15.1.2 [Amendment #8] For the rating period July 1, 2022 through June 30, 2023, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.15.1.3 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, directed payment remittance shall comprise NH Medicaid minimum fee schedule amounts as approved by CMS, including any alternate CMS-approved directed payment methodology.

4.15.16 [Amendment #8:] New Hampshire Hospital and Hampstead Hospital

4.15.16.1 [Amendment #10] [Amendment #8:] Beginning July 1, 2022, the MCO shall reimburse inpatient psychiatric services delivered in state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

4.15.16.1.1 [Amendment #8:] For the rating period July 1, 2022 through June 30, 2023, the facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

4.15.16.1.2 [Amendment #10:] [Amendment #8:] For the rating period July 1, 2023 through August 31, 2024, the facilities shall be reimbursed for inpatient psychiatric services at no less than the NH Medicaid uniform daily rate established and periodically adjusted by the Department of Health and Human Services Commissioner.

4.15.16.2 [Amendment #10:] The MCO shall reimburse inpatient psychiatric professional services delivered in the state-owned New Hampshire Hospital and Hampstead Hospital, as follows:

4.15.16.2.1 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, directed payment amounts shall comprise minimum fee schedule payments at no less than the Medicare rates for inpatient psychiatric professional services delivered in the state-owned facilities.

4.15.17 [Amendment #10:] Payment Standard for Birthing Centers

4.15.17.1 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Provider hospital-based and free-standing birthing centers for Covered Services at no less than NH Medicaid fee schedule rates.

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4.15.18 [Amendment #10:] Qualifying Children's Hospitals

4.15.18.1 [Amendment #10:] The MCO shall remit directed payments to qualifying Children's Hospitals substantively serving NH Medicaid Members, in accordance with separate guidance, as follows:

4.15.18.2 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, a directed payment add-on amount in addition to the MCO's negotiated rate shall be awarded to qualifying Children's Hospitals for each eligible inpatient and outpatient hospital service encounter as approved by CMS.

4.15.19 [Amendment #10:] Payment Standard for Ambulance Services

4.15.19.1 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024, the MCO shall reimburse Participating Providers for all ambulance and chair car Covered Services at no less than NH Medicaid fee schedule rates.

4.16 Readiness Requirements Prior to Operations

4.16.1 General Requirements

4.16.1.1 Prior to the Program Start Date, the MCO shall demonstrate to DHHS's satisfaction its operational readiness and its ability to provide Covered Services to Members at the start of this Agreement in accordance with 42 CFR 438.66(d)(2), (d)(3), and (d)(4). [42 CFR 437.66(d)(1)(i).

4.16.1.2 The readiness review requirements shall apply to all MCOs regardless of whether they have previously contracted with DHHS. [42 CFR 438.66((D(1)(II))]

4.16.1.3 The MCO shall accommodate Readiness desk and site Reviews, including documentation review and system demonstrations as defined by DHHS.

4.16.1.4 The readiness review requirements shall apply to all MCOs, including those who have previously covered benefits to all eligibility groups covered under this Agreement. [42 CFR 438.66(d)(2), (d)(3) and (d)(4)]

4.16.1.5 In order to demonstrate its readiness, the MCO shall cooperate in the Readiness Review conducted by DHHS.

4.16.1.6 If the MCO is unable to demonstrate its ability to meet the requirements of this Agreement, as determined solely by DHHS, within the timeframes determined solely by DHHS, then DHHS shall

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have the right to terminate this Agreement in accordance with Section 7.1 (Termination for Cause).

4.16.1.7 The MCO shall participate in all DHHS trainings in preparation for implementation of the Agreement.

4.16.2 Emergency Response Plan

4.16.2.1 The MCO shall submit an Emergency Response Plan to DHHS for review prior to the Program Start Date.

4.16.2.2 The Emergency Response Plan shall address, at a minimum, the following aspects of pandemic preparedness and natural disaster response and recovery:

4.16.2.2.1 Staff and Provider training;

4.16.2.2.2 Essential business functions and key employees within the organization necessary to carry them out;

4.16.2.2.3 Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;

4.16.2.2.4 Communication with staff, Members, Providers, Subcontractors and suppliers when normal systems are unavailable;

4.16.2.2.5 Plans to ensure continuity of services to Providers and Members;

4.16.2.2.6 How the MCO shall coordinate with and support DHHS and the other MCOs; and

4.16.2.2.7 How the plan shall be tested, updated and maintained.

4.16.2.3 On an annual basis, or as otherwise specified in Exhibit O, the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.

4.17 Managed Care Information System

4.17.1 System Functionality

4.17.1.1 The MCO shall have a comprehensive, automated, and integrated MCIS that:

4.17.1.1.1 Collects, analyzes, integrates, and reports data [42 CFR 438.242(a)];

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4.17.1.1.2 Provides information on areas, including but not limited to utilization, claims, grievances and appeals [42 CFR 438.242(a)];

4.17.1.1.3 Collects and maintains data on Members and Providers, as specified in this Agreement and on all services furnished to Members, through an Encounter Data system [42 CFR 438.242(b)(2)];

4.17.1.1.4 Is capable of meeting the requirements listed throughout this Agreement; and

4.17.1.1.5 Is capable of providing all of the data and information necessary for DHHS to meet State and federal Medicaid reporting and information regulations.

4.17.1.2 The MCO's MCIS shall be capable of submitting Encounter Data, as detailed in Section 5.1.3 (Encounter Data) of this Agreement. The MCO shall provide for:

4.17.1.2.1 Collection and maintenance of sufficient Member Encounter Data to identify the Provider who delivers any item(s) or service(s) to Members;

4.17.1.2.2 Submission of Member Encounter Data to DHHS at the frequency and level of detail specified by CMS and by DHHS;

4.17.1.2.3 Submission of all Member Encounter Data that NH is required to report to CMS; and

4.17.1.2.4 Submission of Member Encounter Data to DHHS in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as specified in this Agreement. [42 CFR 438.242(c)(1) - (4); 42 CFR 438.818]

4.17.1.3 All Subcontractors shall meet the same standards, as described in this Section 4.17 (Managed Care Information System) of the Agreement, as the MCO. The MCO shall be held responsible for errors or noncompliance resulting from the action of a Subcontractor with respect to its provided functions.

4.17.1.4 The MCO MCIS shall include, but not be limited to:

4.17.1.4.1 Management of Recipient Demographic Eligibility and Enrollment and History;

4.17.1.4.2 Management of Provider Enrollment and Credentialing;

4.17.1.4.3 Benefit Plan Coverage Management, History, and Reporting;

4.17.1.4.4 Eligibility Verification;

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- 4.17.1.4.5 Encounter Data;
 - 4.17.1.4.6 Reference File Updates;
 - 4.17.1.4.7 Service Authorization Tracking, Support and Management;
 - 4.17.1.4.8 Third Party Coverage and Cost Avoidance Management;
 - 4.17.1.4.9 Financial Transactions Management and Reporting;
 - 4.17.1.4.10 Payment Management (Checks, electronic funds transfer (EFT), Remittance Advices, Banking);
 - 4.17.1.4.11 Reporting (Ad hoc and Pre-Defined/Scheduled and On-Demand);
 - 4.17.1.4.12 Call Center Management;
 - 4.17.1.4.13 Claims Adjudication;
 - 4.17.1.4.14 Claims Payments; and
 - 4.17.1.4.15 QOS metrics.
- 4.17.1.5 Specific functionality related to the above shall include, but is not limited to, the following:
- 4.17.1.5.1 The MCIS Membership management system shall have the capability to receive, update, and maintain NH's Membership files consistent with information provided by DHHS;
 - 4.17.1.5.2 The MCIS shall have the capability to provide daily updates of Membership information to subcontractors or Providers with responsibility for processing claims or authorizing services based on Membership information;
 - 4.17.1.5.3 The MCIS's Provider file shall be maintained with detailed information on each Provider sufficient to support Provider enrollment and payment and also meet DHHS's reporting and Encounter Data requirements;
 - 4.17.1.5.4 The MCIS's claims processing system shall have the capability to process claims consistent with timeliness and accuracy requirements of a federal MMIS system;
 - 4.17.1.5.5 The MCIS's Services Authorization system shall be integrated with the claims processing system;

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4.17.1.5.6 The MCIS shall be able to maintain its claims history with sufficient detail to meet all DHHS reporting and encounter requirements;

4.17.1.5.7 The MCIS's credentialing system shall have the capability to store and report on Provider specific data sufficient to meet the Provider credentialing requirements, Quality Management, and Utilization Management Program Requirements;

4.17.1.5.8 [Amendment #5:] The MCIS shall be bi-directionally linked to the other operational systems maintained by DHHS, in order to ensure that data captured in encounter records accurately matches data in Member, Provider, claims and authorization files, and in order to enable Encounter Data to be utilized for Member profiling, Provider profiling, claims validation, fraud, waste and abuse monitoring activities, quality improvement, and any other research and reporting purposes defined by DHHS; and

4.17.1.5.9 The Encounter Data system shall have a mechanism in place to receive, process, and store the required data.

4.17.1.6 The MCO system shall be compliant with the requirements of HIPAA and 42 CFR Part 2, including privacy, security, NPI, and transaction processing, including being able to process electronic data interchange (EDI) transactions in the ASC 5010 format. This also includes IRS Pub 1075 where applicable.

4.17.1.7 The MCO system shall be compliant with Section 6504(a) of the Affordable Care Act, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act. [42 CFR 438.242(b)(1)]

4.17.1.8 MCIS capability shall include, but not be limited to the following:

4.17.1.8.1 Provider network connectivity to EDI and Provider portal systems;

4.17.1.8.2 Documented scheduled down time and maintenance windows, as agreed upon by DHHS, for externally accessible systems, including telephony, web, Interactive Voice Response (IVR), EDI, and online reporting;

4.17.1.8.3 DHHS on-line web access to applications and data required by the State to utilize agreed upon workflows, processes,

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and procedures (reviewed by DHHS) to access, analyze, or utilize data captured in the MCO system(s) and to perform appropriate reporting and operational activities;

4.17.1.8.4 DHHS access to user acceptance testing (UAT) environment for externally accessible systems including websites and secure portals;

4.17.1.8.5 Documented instructions and user manuals for each component; and

4.17.1.8.6 Secure access.

4.17.1.9 Managed Care Information System Up-Time

4.17.1.9.1 Externally accessible systems, including telephone, web, IVR, EDI, and online reporting shall be available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year, except for scheduled maintenance upon notification of and pre-approval by DHHS. The maintenance period shall not exceed four (4) consecutive hours without prior DHHS approval.

4.17.1.9.2 MCO shall provide redundant telecommunication backups and ensure that interrupted transmissions shall result in immediate failover to redundant communications path as well as guarantee data transmission is complete, accurate and fully synchronized with operational systems.

4.17.2 Information System Data Transfer

4.17.2.1 Effective communication between the MCO and DHHS requires secure, accurate, complete, and auditable transfer of data to/from the MCO and DHHS data management information systems. Elements of data transfer requirements between the MCO and DHHS management information systems shall include, but not be limited to:

4.17.2.1.1 DHHS read access to all MCM data in reporting databases where data is stored, which includes all tools required to access the data at no additional cost to DHHS;

4.17.2.1.2 Exchanges of data between the MCO and DHHS in a format and schedule as prescribed by the State, including detailed mapping specifications identifying the data source and target;

4.17.2.1.3 Secure (encrypted) communication protocols to provide timely notification of any data file retrieval, receipt, load, or send transmittal issues and provide the requisite analysis and support to

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identify and resolve issues according to the timelines set forth by the State;

4.17.2.1.4 Collaborative relationships with DHHS, its MMIS fiscal agent, and other interfacing entities to effectively implement the requisite exchanges of data necessary to support the requirements of this Agreement;

4.17.2.1.5 MCO implementation of the necessary telecommunication infrastructure and tools/utilities to support secure connectivity and access to the system and to support the secure, effective transfer of data;

4.17.2.1.6 Utilization of data extract, transformation, and load (ETL) or similar methods for data conversion and data interface handling that, to the maximum extent possible, automate the ETL processes, and provide for source to target or source to specification mappings;

4.17.2.1.7 Mechanisms to support the electronic reconciliation of all data extracts to source tables to validate the integrity of data extracts; and

4.17.2.1.8 A given day's data transmissions, as specified in this Section 4.17.2 (Information System Data Transfer) of the Agreement, are to be downloaded to DHHS according to the schedule prescribed by the State. If errors are encountered in batch transmissions, reconciliation of transactions shall be included in the next batch transmission.

4.17.2.2 The MCO shall designate a single point of contact to coordinate data transfer issues with DHHS.

4.17.2.3 DHHS shall provide for a common, centralized electronic project repository, providing for secure access to authorized MCO and DHHS staff for project plans documentation, issues tracking, deliverables, and other project-related artifacts.

4.17.2.4 Data transmissions from DHHS to the MCO shall include, but not be limited to the following:

4.17.2.4.1 Provider Extract (Daily);

4.17.2.4.2 Recipient Eligibility Extract (Daily);

4.17.2.4.3 Recipient Eligibility Audit/Roster (Monthly);

4.17.2.4.4 Medical and Pharmacy Service Authorizations (Daily);

4.17.2.4.5 Medicare and Commercial Third Party Coverage (Daily);

4.17.2.4.6 Claims History (Bi-Weekly); and

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4.17.2.4.7 Capitation Payment data (Monthly).

4.17.2.5 Data transmissions from the MCO to DHHS shall include, but not be limited to the following:

4.17.2.5.1 Member Demographic changes (Daily);

4.17.2.5.2 Member Primary Care Physician Selection (Daily);

4.17.2.5.3 MCO Provider Network Data (Daily);

4.17.2.5.4 Medical and Pharmacy Service Authorizations (Daily);

4.17.2.5.5 Member Encounter Data including paid, denied, adjustment transactions by pay period (Weekly);

4.17.2.5.6 Financial Transaction Data (Weekly);

4.17.2.5.7 Updates to Third Party Coverage Data (Weekly); and

4.17.2.5.8 Behavioral Health Certification Data (Monthly).

4.17.2.6 The MCO shall provide DHHS staff with access to timely and complete data and shall meet the following requirements:

4.17.2.6.1 All exchanges of data between the MCO and DHHS shall be in a format, file record layout, and scheduled as prescribed by DHHS;

4.17.2.6.2 The MCO shall work collaboratively with DHHS, DHHS's MMIS fiscal agent, the NH Department of Information Technology, and other interfacing entities to implement effectively the requisite exchanges of data necessary to support the requirements of this Agreement;

4.17.2.6.3 The MCO shall implement the necessary telecommunication infrastructure to support the MCIS and shall provide DHHS with a network diagram depicting the MCO's communications infrastructure, including but not limited to connectivity between DHHS and the MCO, including any MCO/Subcontractor locations supporting the NH program;

4.17.2.6.4 The MCO shall provide support to DHHS and its fiscal agent to prove the validity, integrity and reconciliation of its data, including Encounter Data;

4.17.2.6.5 The MCO shall be responsible for correcting data extract errors in a timeline set forth by DHHS as outlined within this Agreement;

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4.17.2.6.6 Access shall be secure and data shall be encrypted in accordance with HIPAA regulations and any other applicable State and federal law; and

4.17.2.6.7 Secure access shall be managed via passwords/pins/and any operational methods used to gain access as well as maintain audit logs of all users access to the system.

4.17.3 Systems Operation and Support

4.17.3.1 Systems operations and support shall include, but not be limited to:

4.17.3.1.1 On-call procedures and contacts;

4.17.3.1.2 Job scheduling and failure notification documentation;

4.17.3.1.3 Secure (encrypted) data transmission and storage methodology;

4.17.3.1.4 Interface acknowledgements and error reporting;

4.17.3.1.5 Technical issue escalation procedures;

4.17.3.1.6 Business and Member notification;

4.17.3.1.7 Change control management;

4.17.3.1.8 Assistance with UAT and implementation coordination;

4.17.3.1.9 Documented data interface specifications – data imported and extracts exported including database mapping specifications;

4.17.3.1.10 Disaster Recovery and Business Continuity Plan;

4.17.3.1.11 Journaling and internal backup procedures, for which facility for storage shall be class 3 compliant; and

4.17.3.1.12 Communication and Escalation Plan that fully outlines the steps necessary to perform notification and monitoring of events including all appropriate contacts and timeframes for resolution by severity of the event.

4.17.3.2 The MCO shall be responsible for implementing and maintaining necessary telecommunications and network infrastructure to support the MCIS and shall provide:

4.17.3.2.1 Network diagram that fully defines the topology of the MCO's network;

4.17.3.2.2 DHHS/MCO connectivity;

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4.17.3.2.3 Any MCO/Subcontractor locations requiring MCIS access/support; and

4.17.3.2.4 Web access for DHHS staff, Providers and recipients.

4.17.3.3 [Amendment #9:] The MCO shall utilize either its own or the State's open model Electronic Visit Verification (EVV) system as prescribed by the Department in separate guidance for all Medicaid personal care services and home health Covered Services that require an in-home visit by a Provider in accordance with Section 12006(a) of the 21st Century Cures Act. This applies to personal care services provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver, as applicable.

4.17.4 Ownership and Access to Systems and Data

4.17.4.1 The MCO shall make available to DHHS and, upon request, to CMS all collected data. [42 CFR 438.242(b)(4)]

4.17.4.2 All data accumulated as part of the MCM program shall remain the property of DHHS and upon termination of the Agreement the data shall be electronically transmitted to DHHS in the media format and schedule prescribed by DHHS, and affirmatively and securely destroyed if required by DHHS.

4.17.4.3 Systems enhancements developed specifically, and data accumulated, as part of the MCM program shall remain the property of the State. Source code developed for the MCM program shall remain the property of the MCO but shall be held in escrow.

4.17.4.4 The MCO shall not destroy or purge DHHS's data unless directed to or agreed to in writing by DHHS. The MCO shall archive data only on a schedule agreed upon by DHHS and the data archive process shall not modify the data composition of the source records. All DHHS archived data shall be retrievable for DHHS in the timeframe set forth by DHHS.

4.17.4.5 The MCO shall provide DHHS with system reporting capabilities that shall include access to pre-designed and agreed-upon scheduled reports, as well as the ability to respond promptly to ad-hoc requests to support DHHS data and information needs.

4.17.4.6 DHHS acknowledges the MCO's obligations to appropriately protect data and system performance, and the parties agree to work together to ensure DHHS information needs can be met while minimizing risk and impact to the MCO's systems.

4.17.4.7 Records Retention

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4.17.4.7.1 The MCO shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the Agreement, including paper and electronic claim forms, for a period of not less than ten (10) years from the date of termination of this Agreement.

4.17.4.7.2 Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation.

4.17.4.7.3 Certified protected electronic copies of the documents contemplated herein may be substituted for the originals with the prior written consent of DHHS, if DHHS approves the electronic imaging procedures as reliable and supported by an effective retrieval system.

4.17.4.7.4 Upon expiration of the ten (10) year retention period and upon request, the subject records shall be transferred to DHHS's possession.

4.17.4.7.5 No records shall be destroyed or otherwise disposed of without the prior written consent of DHHS.

4.17.5 Web Access and Use by Providers and Members

4.17.5.1 The MCIS shall include web access for use by and support to Participating Providers and Members.

4.17.5.2 The services shall be provided at no cost to the Participating Provider or Members.

4.17.5.3 All costs associated with the development, security, and maintenance of these websites shall be the responsibility of the MCO.

4.17.5.4 The MCO shall create secure web access for Medicaid Providers and Members and authorized DHHS staff to access case-specific information; this web access shall fulfill the following requirements, and shall be available no later than the Program Start Date:

4.17.5.4.1 Providers shall have the ability to electronically submit service authorization requests and access and utilize other Utilization Management tools;

4.17.5.4.2 Providers and Members shall have the ability to download and print any needed Medicaid MCO program forms and other information;

4.17.5.4.3 Providers shall have an option to e-prescribe without electronic medical records or hand held devices;

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4.17.5.4.4 The MCO shall support Provider requests and receive general program information with contact information for phone numbers, mailing, and e-mail address(es);

4.17.5.4.5 Providers shall have access to drug information;

4.17.5.4.6 The website shall provide an e-mail link to the MCO to permit Providers and Members or other interested parties to e-mail inquiries or comments.

4.17.5.4.7 The website shall provide a link to the State's Medicaid website;

4.17.5.4.8 The website shall be secure and HIPAA compliant in order to ensure the protection of PHI and Medicaid recipient confidentiality.

4.17.5.4.9 Access shall be limited to verified users via passwords and any other available industry standards.

4.17.5.4.10 Audit logs shall be maintained reflecting access to the system and random audits shall be conducted; and

4.17.5.4.11 The MCO shall ensure that any PHI, PI or other Confidential Information solicited on the website, shall not be stored or captured on the website and shall not be further disclosed except as provided by this Agreement.

4.17.5.5 The MCO shall manage Provider and Member access to the system, providing for the applicable secure access management, password, and PIN communication, and operational services necessary to assist Providers and Members with gaining access and utilizing the web portal.

4.17.5.6 System Support Performance Standards shall include:

4.17.5.6.1 Email inquiries – one (1) business day response;

4.17.5.6.2 New information posted within one (1) business day of receipt, and up to two (2) business days of receipt for materials that shall be made ADA compliant with Section 508 of the Rehabilitation Act;

4.17.5.6.3 Routine maintenance;

4.17.5.6.4 Standard reports regarding portal usage such as hits per month by Providers/Members, number, and types of inquiries and requests, and email response statistics as well as maintenance reports; and

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4.17.5.6.5 Website user interfaces shall be ADA compliant with Section 508 of the Rehabilitation Act and support all major browsers (i.e. Chrome, Internet Explorer, Firefox, Safari, etc.). If user does not have compliant browser, MCO shall redirect user to site to install appropriate browser.

4.17.6 Contingency Plans and Quality Assurance

4.17.6.1 Critical systems within the MCIS support the delivery of critical medical services to Members and reimbursement to Providers. As such, contingency plans shall be developed and tested to ensure continuous operation of the MCIS.

4.17.6.2 The MCO shall host the MCIS at the MCO's data center, and provide for adequate redundancy, disaster recovery, and business continuity such that in the event of any catastrophic incident, system availability is restored to NH within twenty-four (24) hours of incident onset.

4.17.6.3 The MCO shall ensure that the NH PHI data, data processing, and data repositories are securely segregated from any other account or project, and that MCIS is under appropriate configuration management and change management processes and subject to DHHS notification requirements.

4.17.6.4 The MCO shall manage all processes related to properly archiving and processing files including maintaining logs and appropriate history files that reflect the source, type and user associated with a transaction.

4.17.6.5 Archiving processes shall not modify the data composition of DHHS's records, and archived data shall be retrievable at the request of DHHS. Archiving shall be conducted at intervals agreed upon between the MCO and DHHS.

4.17.6.6 The MCIS shall be able to accept, process, and generate HIPAA compliant electronic transactions as requested, transmitted between Providers, Provider billing agents/clearing houses, or DHHS and the MCO.

4.17.6.7 Audit logs of activities shall be maintained and periodically reviewed to ensure compliance with security and access rights granted to users.

4.17.6.8 In accordance with Exhibit O, the MCO shall submit the following documents and corresponding checklists for DHHSs review:

4.17.6.8.1 Disaster Recovery Plan;

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4.17.6.8.2 Business Continuity Plan;

4.17.6.8.3 Security Plan;

4.17.6.8.4 The following documents which, if after the original documents are submitted the MCO makes modifications to them, the revised redlined documents and any corresponding checklists shall be submitted for DHHS review:

4.17.6.8.4.1. Risk Management Plan,

4.17.6.8.4.2. Systems Quality Assurance Plan,

4.17.6.8.4.3. Confirmation of 5010 compliance and Companion Guides, and

4.17.6.8.4.4. Confirmation of compliance with IRS Publication 1075.

4.17.6.9 Management of changes to the MCIS is critical to ensure uninterrupted functioning of the MCIS. The following elements, at a minimum, shall be part of the MCO's change management process:

4.17.6.9.1 The complete system shall have proper configuration management/change management in place (to be reviewed by DHHS).

4.17.6.9.2 The MCO system shall be configurable to support timely changes to benefit enrollment and benefit coverage or other such changes.

4.17.6.9.3 The MCO shall provide DHHS with written notice of major systems changes and implementations no later than ninety (90) calendar days prior to the planned change or implementation, including any changes relating to Subcontractors, and specifically identifying any change impact to the data interfaces or transaction exchanges between the MCO and DHHS and/or the fiscal agent.

4.17.6.9.4 DHHS retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

4.17.6.9.5 The MCO shall provide DHHS with updates to the MCIS organizational chart and the description of MCIS responsibilities at least thirty (30) calendar days prior to the effective date of the change, except where personnel changes were not foreseeable in such period, in which case notice shall be given within at least one (1) business day.

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4.17.6.9.6 The MCO shall provide DHHS with official points of contact for MCIS issues on an ongoing basis.

4.17.6.9.7 A NH program centralized electronic repository shall be provided that shall permit full access to project documents, including but not limited to project plans, documentation, issue tracking, deliverables, and any project artifacts. All items shall be turned over to DHHS upon request.

4.17.6.9.8 The MCO shall ensure appropriate testing is done for all system changes. MCO shall also provide a test system for DHHS to monitor changes in externally facing applications (i.e. NH websites). This test site shall contain no actual PHI data of any Member.

4.17.6.9.9 The MCO shall make timely changes or defect fixes to data interfaces and execute testing with DHHS and other applicable entities to validate the integrity of the interface changes.

4.17.6.10 DHHS, or its agent, may conduct a Systems readiness review to validate the MCO's ability to meet the MCIS requirements.

4.17.6.11 The System readiness review may include a desk review and/or an onsite review. If DHHS determines that it is necessary to conduct an onsite review, the MCO shall be responsible for all reasonable travel costs associated with such onsite reviews for at least two (2) staff from DHHS.

4.17.6.12 For purposes of this Section of the Agreement, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by DHHS or its authorized agent in connection with the onsite reviews.

4.17.6.13 If for any reason the MCO does not fully meet the MCIS requirements, the MCO shall, upon request by DHHS, either correct such deficiency or submit to DHHS a CAP and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, DHHS may impose contractual remedies according to the severity of the deficiency as described in Section 5.5 (Remedies) of this Agreement.

4.17.6.14 QOS metrics shall include:

4.17.6.14.1 System Integrity: The MCO system shall ensure that both user and Provider portal design, and implementation is in accordance with federal standards, regulations and guidelines related to security, confidentiality and auditing (e.g. HIPAA Privacy and Security Rules, National Institute of Security and Technology).

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4.17.6.14.2 The security of the Care Management processing system shall minimally provide the following three types of controls to maintain data integrity that directly impacts QOS: These controls shall be in place at all appropriate points of processing:

4.17.6.14.2.1. Preventive Controls: controls designed to prevent errors and unauthorized events from occurring.

4.17.6.14.2.2. Detective Controls: controls designed to identify errors and unauthorized transactions that have occurred in the system.

4.17.6.14.2.3. Corrective Controls: controls to ensure that the problems identified by the detective controls are corrected.

4.17.6.14.3 System Administration: Ability to comply with HIPAA, ADA, and other State and federal regulations, and perform in accordance with Agreement terms and conditions, ability to provide a flexible solution to effectively meet the requirements of upcoming HIPAA regulations and other national standards development.

4.17.6.14.4 The system shall accommodate changes with global impacts (e.g., implementation of electronic health record, e-Prescribe) as well as new transactions at no additional cost.

4.17.7 [Amendment #5:] Interoperability and Patient Access

4.17.7.1 [Amendment #5:] The MCO shall comply with the Centers for Medicare & Medicaid Services published final rule, "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers," (referred to as the "CMS Interoperability and Patient Access final rule") to further advance interoperability for Medicaid and Children's Health Insurance Program (CHIP) providers and improve beneficiaries' access to their data.

4.17.7.2 [Amendment #5:] The MCO shall implement this final rule in a manner consistent with existing guidance and the published "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" final rule (referred to as the ONC 21st Century Cures Act final rule), including:

4.17.7.2.1 [Amendment #5:] Patient Access Application Program Interfaces (API). [42 CFR 438.242(b)(5); 42 CFR 457.1233(d); 85

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Fed. Reg. 25.510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)];

4.17.7.2.2 [Amendment #5:] Provider Directory Application Program Interfaces (API). [42 CFR 438.242(b)(6); 85 Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)]; and

4.17.7.2.3 [Amendment #5:] Implement and maintain a Payer-to-Payer Data Exchange. [42 CFR 438.62(b)(1)(vi)-(vii); 85 Fed. Reg. 25,510-25, 640 (May 1, 2020); 85 Fed. Reg. 25,642-25, 961 (May 1, 2020)].

4.17.7.3 [Amendment #8:] The MCO shall implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60 no later than July 1, 2021, and include(s):

4.17.7.3.1 [Amendment #8:] Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

4.17.7.3.2 [Amendment #8:] Encounter data, including encounter data from any network providers the MCO is compensating on the basis of capitation payments and adjudicated claims and encounter data from any Subcontractors no later than one (1) business day after receiving the data from providers;

4.17.7.3.3 [Amendment #8:] Clinical data, including laboratory results, if the MCO maintains any such data, no later than one (1) business day after the data is received by the state; and

4.17.7.3.4 [Amendment #8:] Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. [42 CFR 438.242(b)(5); 42 CFR 457.1233(d)(2)]

4.17.7.4 [Amendment #8:] The MCO shall implement and maintain a publicly accessible standards-based API no later than July 1, 2021 as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2). [42 CFR 438.242(b)(6); 42 CFR 457.1233(d)(3)]

4.18 Claims Quality Assurance Standards

4.18.1 Claims Payment Standards

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4.18.1.1 [Amendment #7] For purposes of this Section 4.18 (Claims Quality Assurance Standards), DHHS has adopted the claims definitions established by CMS and defined in Section 2.1.25 of this Agreement. [42 CFR 447.45(b)] under the Medicare program, which are as follows:

4.18.1.1.1 ~~"Clean Claim" means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and~~

4.18.1.1.2 ~~"Incomplete Claim" means a claim that is denied for the purpose of obtaining additional information from the Provider.~~

4.18.1.2 Claims payment timeliness shall be measured from the received date, which is the date a paper claim is received in the MCO's mailroom by its date stamp or the date an electronic claim is submitted.

4.18.1.3 The paid date is the date a payment check or EFT is issued to the service Provider [42 CFR 447.45(d)(5) - (6); 42 CFR 447.46; sections 1932(f) and 1902(a)(37)(A) of the Act]

4.18.1.4 The denied date is the date at which the MCO determines that the submitted claim is not eligible for payment.

4.18.1.5 The MCO shall pay or deny ninety-five percent (95%) of Clean Claims within thirty (30) calendar days of receipt, or receipt of additional information.

4.18.1.6 The MCO shall pay ninety-nine percent (99%) of Clean Claims within ninety (90) calendar days of receipt. [42 CFR 447.46; 42 CFR 447.45(d)(2)-(3) and (d)(5)-(6); Sections 1902(a)(37)(A) and 1932(f) of the Social Security Act].

4.18.1.7 The MCO shall request all additional information necessary to process Incomplete Claims from the Provider within thirty (30) calendar days from the date of original claim receipt.

4.18.2 Claims Quality Assurance Program

4.18.2.1 The MCO shall verify the accuracy and timeliness of data reported by Providers, including data from Participating Providers the MCO is compensating through a capitated payment arrangement.

4.18.2.2 The MCO shall screen the data received from Providers for completeness, logic, and consistency [42 CFR 438.242(b)(3)(i)-(ii)].

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4.18.2.3 The MCO shall maintain an internal program to routinely measure the accuracy of claims processing for MCIS and report results to DHHS, in accordance with Exhibit O.

4.18.2.4 As indicated in Exhibit O, reporting to DHHS shall be based on a review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims.

The MCO shall implement CAPs to identify any issues and/or errors identified during claim reviews and report resolution to DHHS.

4.18.3 Claims Financial Accuracy

4.18.3.1 Claims financial accuracy measures the accuracy of dollars paid to Providers. It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.

4.18.3.2 The MCO shall pay ninety-nine percent (99%) of dollars accurately.

4.18.4 Claims Payment Accuracy

4.18.4.1 Claims payment accuracy measures the percentage of claims paid or denied correctly. It is measured by dividing the number of claims paid/denied correctly by the total claims reviewed.

4.18.4.2 The MCO shall pay ninety-seven percent (97%) of claims accurately.

4.18.5 Claims Processing Accuracy

4.18.5.1 Claims processing accuracy measures the percentage of claims that are accurately processed in their entirety from both a financial and non-financial perspective; i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc. It is measured by dividing the total number of claims processed correctly by the total number of claims reviewed.

4.18.5.2 The MCO shall process ninety-five percent (95%) of all claims correctly.

5 OVERSIGHT AND ACCOUNTABILITY

5.1 Reporting

5.1.1 General Provisions

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5.1.1.1 As indicated throughout this Agreement, DHHS shall document ongoing MCO reporting requirements through Exhibit O and additional specifications provided by DHHS.

5.1.1.2 The MCO shall provide data, reports, and plans in accordance with Exhibit O, this Agreement, and any additional specifications provided by DHHS.

5.1.1.3 The MCO shall comply with all NHID rules for data reporting, including those related to the NH CHIS.

5.1.1.4 The MCO shall make all collected data available to DHHS upon request and upon the request of CMS. [42 CFR 438.242(b)(4)]

5.1.1.5 The MCO shall collect data on Member and Provider characteristics as specified by DHHS and on services furnished to Members through a MCIS system or other methods as may be specified by DHHS. [42 CFR 438.242(b)(2)]

5.1.1.6 The MCO shall ensure that data received from Providers are accurate and complete by:

5.1.1.6.1 Verifying the accuracy and timeliness of reported data;

5.1.1.6.2 Screening the data for completeness, logic, and consistency; and

5.1.1.6.3 Collecting service information in standardized formats to the extent feasible and appropriate. [42 CFR 438.242(b)(3)]

5.1.1.7 DHHS shall at a minimum collect, and the MCO shall provide, the following information, and the information specified throughout the Agreement and within Exhibit O, in order to improve the performance of the MCM program [42 CFR 438.66(c)(1)-(2) and (6)-(11)]:

5.1.1.7.1 Enrollment and disenrollment data;

5.1.1.7.2 Member grievance and appeal logs;

5.1.1.7.3 Medical management committee reports and minutes;

5.1.1.7.4 Audited financial and encounter data;

5.1.1.7.5 The MLR summary reports;

5.1.1.7.6 Customer service performance data;

5.1.1.7.7 Performance on required quality measures; and

5.1.1.7.8 The MCO's QAPI Plan.

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5.1.1.8 The MCO shall be responsible for preparing, submitting, and presenting to the Governor, Legislature, and DHHS a report that includes the following information, or information otherwise indicated by the State:

5.1.1.8.1 A description of how the MCO has addressed State priorities for the MCM Program, including those specified in RSA 126-AA, throughout this Agreement, and in other State statute, policies, and guidelines;

5.1.1.8.2 A description of the innovative programs the MCO has developed and the outcomes associated with those programs;

5.1.1.8.3 A description of how the MCO is addressing social determinants of health and the outcomes associated with MCO-implemented interventions;

5.1.1.8.4 A description of how the MCO is improving health outcomes in the state; and

5.1.1.8.5 Any other information indicated by the State for inclusion in the annual report.

5.1.1.9 Prior to Program Start Date and at any other time upon DHHS request or as indicated in this Agreement, DHHS shall conduct a review of MCO policies and procedures and/or other administrative documentation.

5.1.1.9.1 DHHS shall deem materials as pass or fail following DHHS review.

5.1.1.9.2 The MCO shall complete and submit a DHHS-developed attestation that attests that the policy, procedure or other documentation satisfies all applicable State and federal authorities.

5.1.1.9.3 DHHS may require modifications to MCO policies and procedures or other documentation at any time as determined by DHHS.

5.1.2 Requirements for Waiver Programs

5.1.2.1 The MCO shall provide to DHHS the data and information required for its current CMS waiver programs and any waiver programs it enters during the Term of this Agreement that require data for Members covered by the MCO. These include but are not limited to:

5.1.2.1.1 NH's Building Capacity for Transformation 1115 waiver;

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5.1.2.1.2 [Amendment #8:] Substance Use Disorder and Severe Mental Illness Institute for Mental Disease 1115 waivers (subject to CMS approval);

5.1.2.1.3 Mandatory managed care 1915b waiver; and

5.1.2.1.4 Granite Advantage 1115 waiver.

5.1.3 Encounter Data

5.1.3.1 The MCO shall submit Encounter Data in the format and content, timeliness, completeness, and accuracy as specified by DHHS and in accordance with timeliness, completeness, and accuracy standards as established by DHHS. [42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818]

5.1.3.2 All MCO encounter requirements apply to all Subcontractors. The MCO shall ensure that all contracts with Participating Providers and Subcontractors contain provisions that require all encounter records are reported or submitted in an accurate and timely fashion such that the MCO meets all DHHS reporting requirements.

5.1.3.3 The MCO shall submit to DHHS for review, during the Readiness Review process, its policies and procedures that detail the MCO's encounter process. The MCO-submitted policies and procedures shall at minimum include to DHHS's satisfaction:

5.1.3.3.1 An end-to-end description of the MCO's encounter process;

5.1.3.3.2 A detailed overview of the encounter process with all Providers and Subcontractors; and

5.1.3.3.3 A detailed description of the internal reconciliation process followed by the MCO, and all Subcontractors that process claims on the MCO's behalf.

5.1.3.4 The MCO shall, as requested by DHHS, submit updates to and revise upon request its policies and procedures that detail the MCO's encounter process.

5.1.3.5 All Encounter Data shall remain the property of DHHS and DHHS retains the right to use it for any purpose it deems necessary.

5.1.3.6 The MCO shall submit Encounter Data to the EQRO and DHHS in accordance with this Section 5.1.3 (Encounter Data) of the Agreement and to DHHS's actuaries, as requested, according to the format and specification of the actuaries.

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5.1.3.7 Submission of Encounter Data to DHHS does not eliminate the MCO's responsibility to comply with NHID rules, Chapter Ins 4000 Uniform Reporting System for Health Care Claims Data Sets.

5.1.3.8 The MCO shall ensure that encounter records are consistent with DHHS requirements and all applicable State and federal laws.

5.1.3.9 MCO encounters shall include all adjudicated claims, including paid, denied, and adjusted claims.

5.1.3.10 The level of detail associated with encounters from Providers with whom the MCO has a capitated payment arrangement shall be the equivalent to the level of detail associated with encounters for which the MCO received and settled a FFS claim.

5.1.3.11 The MCO shall maintain a record of all information submitted by Providers on claims. All Provider-submitted claim information shall be submitted in the MCO's encounter records.

5.1.3.12 The MCO shall have a computer and data processing system, and staff, sufficient to accurately produce the data, reports, and encounter record set in formats and timelines as defined in this Agreement.

5.1.3.13 The system shall be capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

5.1.3.14 The MCO shall collect service information in the federally mandated HIPAA transaction formats and code sets, and submit these data in a standardized format approved by DHHS.

5.1.3.15 The MCO shall make all collected data available to DHHS after it is tested for compliance, accuracy, completeness, logic, and consistency.

5.1.3.16 The MCO's systems that are required to use or otherwise contain the applicable data type shall conform to current and future HIPAA-based standard code sets; the processes through which the data are generated shall conform to the same standards, including application of:

5.1.3.16.1 Health Care Common Procedure Coding System (HCPCS);

5.1.3.16.2 CPT codes;

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5.1.3.16.3 International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM and International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS;

5.1.3.16.4 National Drug Codes which is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. It is maintained and distributed by HHS, in collaboration with drug manufacturers;

5.1.3.16.5 Code on Dental Procedures and Nomenclature (CDT) which is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA);

5.1.3.16.6 POS Codes which are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry;

5.1.3.16.7 Claim Adjustment Reason Codes (CARC) which explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the Provider or the patient when other insurance is involved; and

5.1.3.16.8 Reason and Remark Codes (RARC) which are used when other insurance denial information is submitted to the MMIS using standard codes defined and maintained by CMS and the NCPDP.

5.1.3.17 All MCO encounters shall be submitted electronically to DHHS or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) or at the discretion of DHHS the ANSI X12N 837 post adjudicated transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NH file format, and other proprietary file layouts as defined by DHHS.

5.1.3.18 All MCO encounters shall be submitted with MCO paid amount, or FFS equivalent, and, as applicable, the Medicare paid amount, other insurance paid amount and/or expected Member Copayment amount.

5.1.3.19 [Amendment #5:] The paid amount (or FFS equivalent) submitted with Encounter Data shall be the amount paid to Providers, not the amount paid to MCO Subcontractors or Providers of shared services within the MCO's organization, third party administrators, or capitated entities. This requirement means that, for example for pharmacy claims, the MCO paid amount shall include the amount

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paid to the pharmacy and exclude any and all fees paid by the MCO to the Pharmacy Benefit Manager. The amount paid to the MCO's PBM is not acceptable.

5.1.3.20 The MCO shall continually provide up to date documentation of payment methods used for all types of services by date of use of said methods.

5.1.3.21 The MCO shall continually provide up to date documentation of claim adjustment methods used for all types of claims by date of use of said methods.

5.1.3.22 The MCO shall collect, and submit to the State's fiscal agent, Member service level Encounter Data for all Covered Services.

5.1.3.23 The MCO shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

5.1.3.24 The MCO shall conform to all current and future HIPAA-compliant standards for information exchange, including but not limited to the following requirements:

5.1.3.24.1 Batch and Online Transaction Types are as follows:

5.1.3.24.1.1. ASC X12N 820 Premium Payment Transaction;

5.1.3.24.1.2. ASC X12N 834 Enrollment and Audit Transaction;

5.1.3.24.1.3. ASC X12N 835 Claims Payment Remittance Advice Transaction;

5.1.3.24.1.4. ASC X12N 837I Institutional Claim/Encounter Transaction;

5.1.3.24.1.5. ASC X12N 837P Professional Claim/Encounter Transaction;

5.1.3.24.1.6. ASC X12N 837D Dental Claim/Encounter Transaction; and

5.1.3.24.1.7. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.24.2 Online transaction types are as follows:

5.1.3.24.2.1. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

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- 5.1.3.24.2.2. ASC X12N 276 Claims Status Inquiry;
- 5.1.3.24.2.3. ASC X12N 277 Claims Status Response;
- 5.1.3.24.2.4. ASC X12N 278/279 Utilization Review Inquiry/Response; and
- 5.1.3.24.2.5. NCPDP D.0 Pharmacy Claim/Encounter Transaction.

5.1.3.25 Submitted Encounter Data shall include all elements specified by DHHS, including but not limited to those specified in the DHHS Medicaid Encounter Submission Requirements Policy.

5.1.3.26 The MCO shall submit summary reporting in accordance with Exhibit O, to be used to validate Encounter submissions.

5.1.3.27 The MCO shall use the procedure codes, diagnosis codes, and other codes as directed by DHHS for reporting Encounters and fee- for-service claims.

5.1.3.28 Any exceptions shall be considered on a code-by-code basis after DHHS receives written notice from the MCO requesting an exception.

5.1.3.29 The MCO shall use the Provider identifiers as directed by DHHS for both Encounter and FFS submissions, as applicable.

5.1.3.30 The MCO shall provide, as a supplement to the Encounter Data submission, a Member file on a monthly basis, which shall contain appropriate Member Medicaid identification numbers, the PCP assignment of each Member, and the group affiliation and service location address of the PCP.

5.1.3.31 The MCO shall submit complete Encounter Data in the appropriate HIPAA-compliant formats regardless of the claim submission method (hard copy paper, proprietary formats, EDI, DDE).

5.1.3.32 The MCO shall assign staff to participate in encounter technical work group meetings as directed by DHHS.

5.1.3.33 The MCO shall provide complete and accurate encounters to DHHS.

5.1.3.34 The MCO shall implement review procedures to validate Encounter Data submitted by Providers. The MCO shall meet the following standards:

- 5.1.3.34.1 Completeness:

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5.1.3.34.1.1. The MCO shall submit encounters that represent one hundred percent (100%) of the Covered Services provided by Participating Providers and Non-Participating Providers.

5.1.3.34.2 Accuracy:

5.1.3.34.2.1. Transaction type (X12): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits. The standard shall apply to submissions of each individual batch and online transaction type.

5.1.3.34.2.2. Transaction type (NCPDP): Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP.

5.1.3.34.2.3. One-hundred percent (100%) of Member identification numbers shall be accurate and valid.

5.1.3.34.2.4. Ninety-eight percent (98%) of billing Provider information shall be accurate and valid.

5.1.3.34.2.5. Ninety-eight percent (98%) of servicing Provider information shall be accurate and valid.

5.1.3.34.2.6. The MCO shall submit a monthly supplemental Provider file, to include data elements as defined by DHHS, for all Providers that were submitted on encounters in the prior month.

5.1.3.34.2.7. For the first six (6) months of encounter production submissions, the MCO shall conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Data quality.

5.1.3.34.2.7.1 The end to end test shall include a review of the Provider claim to what data is in the MCO claims processing system, and the encounter file record produced for that claim.

5.1.3.34.2.7.2 The MCO shall report a pass or fail to DHHS. If the result is a fail, the MCO shall also

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submit a root cause analysis that includes plans for remediation.

5.1.3.34.2.7.3 If DHHS or the MCO identifies a data defect, the MCO shall, for six (6) months post data defect identification, conduct a monthly end to end test of a statistically valid sample of claims to ensure Encounter Data quality.

5.1.3.34.2.7.4 If two (2) or more Encounter Data defects are identified within a rolling twelve (12) month period, DHHS may require the MCO to contract with an external vendor to independently assess the MCO Encounter Data process. The external vendor shall produce a report that shall be shared with DHHS.

5.1.3.34.3 Timeliness:

5.1.3.34.3.1. Encounter Data shall be submitted weekly, within fourteen (14) calendar days of claim payment.

5.1.3.34.3.2. All encounters shall be submitted, both paid and denied claims.

5.1.3.34.3.3. The MCO shall be subject to liquidated damages as specified in Section 5.5.2 (Liquidated Damages) for failure to timely submit Encounter Data, in accordance with the accuracy standards established in this Agreement.

5.1.3.34.4 Error Resolution:

5.1.3.34.4.1. For all historical encounters submitted after the submission start date, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all related encounters within forty-five (45) calendar days after such notice.

5.1.3.34.4.2. For all ongoing claim encounters, if DHHS or its fiscal agent notifies the MCO of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the MCO shall remediate all such encounters within fourteen (14) calendar days after such notice.

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5.1.3.34.4.3. If the MCO fails to comply with either error resolution timeline, DHHS shall require a CAP and assess liquidated damages as described in Section 5.5.2 (Liquidated Damages).

5.1.3.34.4.4. The MCO shall not be held accountable for issues or delays directly caused by or as a direct result of the changes to MMIS by DHHS.

5.1.3.34.5 Survival:

5.1.3.34.5.1. All Encounter Data accumulated as part of the MCM program shall remain the property of DHHS and, upon termination of the Agreement, the data shall be electronically transmitted to DHHS in a format and schedule prescribed by DHHS and as is further described in Section 7.7.2 (Data).

5.1.4 Data Certification

5.1.4.1 All data submitted to DHHS by the MCO shall be certified by one (1) of the following:

5.1.4.1.1 The MCO's CEO;

5.1.4.1.2 The MCO's CFO; or

5.1.4.1.3 An individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. [42 CFR 438.604; 42 CFR 438.606(a)]

5.1.4.2 The data that shall be certified include, but are not limited to, all documents specified by DHHS, enrollment information, Encounter Data, and other information contained in this Agreement or proposals.

5.1.4.3 The certification shall attest to, based on best knowledge, information, and belief, the accuracy, completeness and truthfulness of the documents and data.

5.1.4.4 The MCO shall submit the certification concurrently with the certified data and documents [42 CFR 438.604; 42 CFR 438.606].

5.1.4.5 The MCO shall submit the MCO Data Certification process policies and procedures for DHHS review during the Readiness Review process.

5.1.5 Data System Support for Quality Assurance & Performance Improvement

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5.1.5.1 The MCO shall have a data collection, processing, and reporting system sufficient to support the QAPI program requirements described in Section 4.12.3 (Quality Assessment and Performance Improvement Program).

5.1.5.2 The system shall be able to support QAPI monitoring and evaluation activities, including the monitoring and evaluation of the quality of clinical care provided, periodic evaluation of Participating Providers, Member feedback on QAPI activity, and maintenance and use of medical records used in QAPI activities.

5.2 Contract Oversight Program

5.2.1 The MCO shall have a formalized Contract Oversight Program to ensure that it complies with this Agreement, which at a minimum, should outline:

5.2.1.1 The specific monitoring and auditing activities that the MCO shall undertake to ensure its and its Subcontractors' compliance with certain provisions and requirements of the Agreement;

5.2.1.2 The frequency of those contract oversight activities; and

5.2.1.3 The person(s) responsible for those contract oversight activities.

5.2.2 The Contract Oversight Program shall specifically address how the MCO shall oversee the MCO's and its Subcontractor's compliance with the following provisions and requirements of the Agreement:

5.2.2.1 Section 3.12 (Privacy and Security of Members' Information);

5.2.2.2 Section 3.14 (Subcontractors);

5.2.2.3 Section 4 (Program Requirements); and

5.2.2.4 All data and reporting requirements.

5.2.3 The Contract Oversight Program shall set forth how the MCO's Chief Executive Officer (CEO)/Executive Director, Compliance Officer and Board of Directors shall be made aware of non-compliance identified through the Contract Oversight Program.

5.2.4 The MCO shall present to DHHS for review as part of the Readiness Review a copy of the Contract Oversight Program and any implementing policies.

5.2.5 The MCO shall present to DHHS for review redlined copies of proposed changes to the Contract Oversight Program and its implementing policies prior to adoption.

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5.2.6 This Contract Oversight Program is distinct from the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan discussed in Section 5.3 (Program Integrity).

5.2.7 The MCO shall promptly, but no later than thirty (30) calendar days after the date of discovery, report any material non-compliance identified through the Contract Oversight Program and submit a Corrective Action Plan to DHHS to remediate such non-compliance.

5.2.8 The MCO shall implement any changes to the Corrective Action Plan requested by DHHS.

5.3 Program Integrity

5.3.1 General Requirements

5.3.1.1 The MCO shall present to DHHS for review, as part of the Readiness Review process, a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan and shall comply with policies and procedures that guide and require the MCO and the MCO's officers, employees, agents and Subcontractors to comply with the requirements of this Section 5.3 (Program Integrity). [42 CFR 438.608]

5.3.1.2 The MCO shall present to DHHS for review redlined copies of proposed changes to the Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan prior to adoption.

5.3.1.3 The MCO shall include program integrity requirements in its Subcontracts and provider application, credentialing and recredentialing processes.

5.3.1.4 The MCO is expected to be familiar with, comply with, and require compliance by its Subcontractors with all regulations and sub-regulatory guidance related to program integrity whether or not those regulations are listed below:

5.3.1.4.1 Section 1902(a)(68) of the Social Security Act;

5.3.1.4.2 42 CFR Section 438;

5.3.1.4.3 42 CFR Section 455;

5.3.1.4.4 42 CFR Section 1000 through 1008; and

5.3.1.4.5 CMS Toolkits.

5.3.1.5 The MCO shall ensure compliance with the program integrity provisions of this Agreement, including proper payments to providers or Subcontractors, methods for detection and prevention of

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fraud, waste and abuse and the MCO's and its Subcontractors' compliance with all program integrity reporting requirements to DHHS.

5.3.1.6 The MCO shall have a Program Integrity Plan and a Fraud, Waste and Abuse Compliance Plan that are designed to guard against fraud, waste and abuse.

5.3.1.7 The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan shall include, at a minimum, the establishment and implementation of internal controls, policies, and procedures to prevent and deter fraud, waste and abuse.

5.3.1.8 The MCO shall be compliant with all applicable federal and State regulations related to Medicaid program integrity. [42 CFR 455, 42 CFR 456, 42 CFR 438, 42 CFR 1000 through 1008 and Section 1902(a)(68) of the Social Security Act]

5.3.1.9 The MCO shall work with DHHS on program integrity issues, and with MFCU as directed by DHHS, on fraud, waste or abuse investigations. This shall include, at a minimum, the following:

5.3.1.9.1 Participation in MCO program integrity meetings with DHHS following the submission of the monthly allegation log submitted by the MCO in accordance with Exhibit O.

5.3.1.9.2 The frequency of the program integrity meetings shall be as often as monthly.

5.3.1.9.3 Discussion at these meetings shall include, but not be limited to, case development and monitoring.

5.3.1.9.4 The MCO shall ensure Subcontractors attend monthly meetings when requested by DHHS;

5.3.1.9.5 Participation in bi-annual MCO and Subcontractor forums to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned;

5.3.1.9.6 Quality control and review of encounter data submitted to DHHS; and

5.3.1.9.7 Participation in meetings with MFCU, as determined by MFCU and DHHS.

5.3.2 Fraud, Waste and Abuse

5.3.2.1 The MCO, or a Subcontractor which has been delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain administrative and

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management arrangements or procedures designed to detect and prevent fraud, waste and abuse. [42 CFR 438.608(a)]

5.3.2.2 The arrangements or procedures shall include the following:

5.3.2.2.1 The Program Integrity Plan and the Fraud, Waste and Abuse Compliance Plan that includes, at a minimum, all of the following elements:

5.3.2.2.1.1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under this Agreement, and all applicable federal and State requirements;

5.3.2.2.1.2. Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the Agreement and who directly reports to the CEO and the Board of Directors;

5.3.2.2.1.3. Establishment of a Regulatory Compliance Committee of the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with this Agreement;

5.3.2.2.1.4. System for training and education for the Compliance Officer, the MCO's senior management, employees, and Subcontractor on the federal and State standards and requirements under this Agreement;

5.3.2.2.1.5. Effective lines of communication between the Compliance Officer and MCO's staff and Subcontractors;

5.3.2.2.1.6. Enforcement of standards through well-publicized disciplinary guidelines; and

5.3.2.2.1.7. Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination

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of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement. [42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i) - (vii)]

5.3.2.2.2 The process by which the MCO shall monitor their marketing representative activities to ensure that the MCO does not engage in inappropriate activities, such as inducements;

5.3.2.2.3 A requirement that the MCO shall report on staff termination for engaging in prohibited marketing conduct or fraud, waste and abuse to DHHS within thirty (30) business days;

5.3.2.2.4 A description of the MCO's specific controls to detect and prevent potential fraud, waste and abuse including, without limitation:

5.3.2.2.4.1. A list of automated pre-payment claims edits, including National Correct Coding Initiative (NCCI) edits;

5.3.2.2.4.2. A list of automated post-payment claims edits;

5.3.2.2.4.3. In accordance with 42 CFR 438.602(b), the MCO shall maintain edits on its claims systems to ensure in-network claims include New Hampshire Medicaid enrolled billing and rendering provider NPIs. The MCO shall amend edits on its claims systems as required by any changes in federal and State requirements for managed care billing;

5.3.2.2.4.4. At least three (3) data analytic algorithms for fraud detection specified by DHHS Program Integrity and three (3) additional data analytic algorithms as determined by the MCO for a total of at least six (6) algorithms, which should include services provided by Subcontractors. These algorithms are subject to change at least annually;

5.3.2.2.4.5. A list of audits of post-processing review of claims planned;

5.3.2.2.4.6. A list of reports on Participating Provider and Non-Participating Provider profiling used to aid program integrity reviews;

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5.3.2.2.4.7. The methods the MCO shall use to identify high-risk claims and the MCO's definition of "high-risk claims";

5.3.2.2.4.8. Visit verification procedures and practices, including sample sizes and targeted provider types or locations;

5.3.2.2.4.9. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

5.3.2.2.4.10. A method to verify, by sampling or other method, whether services that have been represented to have been delivered by Participating Providers and were received by Members and the application of such verification processes on a regular basis. The MCO may use an explanation of benefits (EOB) for such verification only if the MCO suppresses information on EOBs that would be a violation of Member confidentiality requirements for women's health care, family planning, sexually transmitted diseases, and behavioral health services [42 CFR 455.20];

5.3.2.2.4.11. Provider and Member materials identifying the MCO's fraud and abuse reporting hotline number;

5.3.2.2.4.12. Work plans for conducting both announced and unannounced site visits and field audits of Participating Providers determined to be at high risk to ensure services are rendered and billed correctly;

5.3.2.2.4.13. The process for putting a Participating Provider on and taking a Participating Provider off prepayment review, including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate;

5.3.2.2.4.14. The ability to suspend a Participating Provider's or Non-Participating Provider's payment due to credible allegation of fraud if directed by DHHS Program Integrity; and

5.3.2.2.4.15. The process by which the MCO shall recover inappropriately paid funds if the MCO discovers wasteful and/or abusive, incorrect billing trends with a

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particular Participating Provider or provider type, specific billing issue trends, or quality trends.

5.3.2.2.5 A provision for the prompt reporting of all Overpayments identified and recovered, specifying the Overpayments due to potential fraud;

5.3.2.2.6 A provision for referral of any potential Participating Provider or Non-Participating Provider fraud, waste and abuse that the MCO or Subcontractor identifies to DHHS Program Integrity and any potential fraud directly to the MFCU as required under this Agreement [42 CFR 438.608(a)(7)];

5.3.2.2.7 A provision for the MCO's suspension of payments to a Participating Provider for which DHHS determines there is credible allegation of fraud in accordance with this Agreement and 42 CFR 455.23; and

5.3.2.2.8 A provision for notification to DHHS when the MCO receives information about a change in a Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in the MCM program, including the termination of the provider agreement with the MCO as detailed in Exhibit O.

5.3.2.3 The MCO and Subcontractors shall implement and maintain written policies for all employees and any Subcontractor or agent of the entity, that provide detailed information about the False Claims Act (FCA) and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Social Security Act; 42 CFR 438.608(a)(6)]

5.3.2.4 The MCO, and if required by the MCO's Subcontractors, shall post and maintain DHHS-approved information related to fraud, waste and abuse on its website, including but not limited to, provider notices, current listing of Participating Providers, providers that have been excluded or sanctioned from the Medicaid Care Management Program, any updates, policies, provider resources, contact information and upcoming educational sessions/webinars.

5.3.3 Identification and Recoveries of Overpayments

5.3.3.1 The MCO shall maintain an effective fraud, waste and abuse-related Provider overpayment identification, Recovery and tracking process.

5.3.3.2 The MCO shall perform ongoing analysis of its authorization, utilization, claims, Provider's billing patterns, and

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encounter data to detect improper payments, and shall perform audits and investigations of Subcontractors, Providers and Provider entities.

5.3.3.3 This process shall include a methodology for a means of estimating overpayment, a formal process for documenting communication with Providers, and a system for managing and tracking of investigation findings, Recoveries, and underpayments related to fraud, waste and abuse investigations/audit/any other overpayment recovery process as described in the fraud, waste and abuse reports provided to DHHS in accordance with Exhibit O.

5.3.3.4 The MCO and Subcontractors shall each have internal policies and procedures for documentation, retention and recovery of all Overpayments, specifically for the recovery of Overpayments due to fraud, waste and abuse, and for reporting and returning Overpayments as required by this Agreement. [42 CFR 438.608(d)(1)(i)]

5.3.3.5 The MCO and its subcontractors shall report to DHHS within sixty (60) calendar days when it has identified Capitation Payments or other payment amounts received are in excess to the amounts specified in this Agreement. [42 CFR 438.608(c)(3)].

5.3.3.6 DHHS may recover Overpayments that are not recovered by or returned to the MCO within sixty (60) calendar days of notification by DHHS to pursue.

5.3.3.7 This Section of the Agreement does not apply to any amount of a recovery to be retained under False Claim Act cases or through other investigations.

5.3.3.8 Any settlement reached by the MCO or its subcontractors and a Provider shall not bind or preclude the State from further action.

5.3.3.9 DHHS shall utilize the information and documentation collected under this Agreement, as well as nationally recognized information on average recovery amounts as reported by State MFCUs and commercial insurance plans for setting actuarially sound Capitation Payments for each MCO consistent with the requirements in 42 CFR 438.4.

5.3.3.10 If the MCO does not meet the required metrics related to expected fraud referrals, overpayment recoupments, and other measures set forth in this Agreement and Exhibit O, DHHS shall impose liquidated damages, unless the MCO can demonstrate good cause for failure to meet such metrics.

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5.3.4 Referrals of Credible Allegations of Fraud and Provider and Payment Suspensions

5.3.4.1 General

5.3.4.1.1 The MCO shall, and shall require any Subcontractor to, establish policies and procedures for referrals to DHHS Program Integrity Unit and the MFCU on credible allegations of fraud and for payment suspension when there is a credible allegation of fraud. [42 CFR 438.608(a)(8); 42 CFR 455.23].

5.3.4.1.2 The MCO shall complete a DHHS "Request to Open" form for any potential fraud, waste, or abuse case, including those that lead to a credible allegation of fraud. DHHS Program Integrity Unit shall have fifteen (15) business days to respond to the MCO's "Request to Open" form.

5.3.4.1.3 When the MCO or its Subcontractor has concluded that a credible allegation of fraud or abuse exists, the MCO shall make a referral to DHHS Program Integrity Unit and any potential fraud directly to MFCU within five (5) business days of the determination on a template provided by DHHS. [42 CFR 438.608(a)(7)]

5.3.4.1.4 Unless and until prior written approval is obtained from DHHS, neither the MCO nor a Subcontractor shall take any administrative action or any of the following regarding the allegations of suspected fraud:

5.3.4.1.4.1. Suspend Provider payments;

5.3.4.1.4.2. Contact the subject of the investigation about any matters related to the investigation;

5.3.4.1.4.3. Continue the investigation into the matter;

5.3.4.1.4.4. Enter into or attempt to negotiate any settlement or agreement regarding the matter; or

5.3.4.1.4.5. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

5.3.4.1.5 The MCO shall employ pre-payment review when directed by DHHS.

5.3.4.1.6 In addition, the MCO may employ pre-payment review in the following circumstances without approval:

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- 5.3.4.1.6.1. Upon new Participating Provider enrollment;
- 5.3.4.1.6.2. For delayed payment during Provider education;
- 5.3.4.1.6.3. For existing Providers with billing inaccuracies;
- 5.3.4.1.6.4. Upon receipt of a credible allegation of fraud or abuse; or
- 5.3.4.1.6.5. Upon identification from data analysis or other grounds.

5.3.4.1.7 If DHHS, MFCU or another law enforcement agency accepts the allegation for investigation, DHHS shall notify the MCO's Compliance Officer within two (2) business days of the acceptance notification, along with a directive to suspend payment to the affected Provider(s) if it is determined that suspension shall not impair MFCU's or law enforcement's investigation.

5.3.4.1.8 DHHS shall notify the MCO if the referral is declined for investigation.

5.3.4.1.9 If DHHS, MFCU, or other law enforcement agencies decline to investigate the fraud referral, the MCO may proceed with its own investigation and comply with the reporting requirements contained in this Section of the Agreement.

5.3.4.1.10 Upon receipt of notification from DHHS, the MCO shall send notice of the decision to suspend program payments to the Provider within the following timeframe:

5.3.4.1.10.1. Within five (5) calendar days of taking such action unless requested in writing by DHHS, the MFCU, or law enforcement to temporarily withhold such notice; or

5.3.4.1.10.2. Within thirty (30) calendar days if requested by DHHS, MFCU, or law enforcement in writing to delay sending such notice.

5.3.4.1.10.3. The request for delay may be renewed in writing no more than twice and in no event may the delay exceed ninety (90) calendar days.

5.3.4.1.11 The notice shall include or address all of the following (42 CFR 455.23(2)):

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5.3.4.1.11.1. That payments are being suspended in accordance with this provision;

5.3.4.1.11.2. Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation;

5.3.4.1.11.3. That the suspension is for a temporary period and cite the circumstances under which the suspension shall be lifted;

5.3.4.1.11.4. Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

5.3.4.1.11.5. Where applicable and appropriate, inform the Provider of any appeal rights available to the Provider, along with the Provider's right to submit written evidence for consideration by the MCO.

5.3.4.2 All suspension of payment actions under this Section of the Agreement shall be temporary and shall not continue after either of the following:

5.3.4.2.1 The MCO is notified by DHHS that there is insufficient evidence of fraud by the Provider; or

5.3.4.2.2 The MCO is notified by DHHS that the legal proceedings related to the Provider's alleged fraud are completed.

5.3.4.3 The MCO shall document in writing the termination of a payment suspension and issue a notice of the termination to the Provider and to DHHS.

5.3.4.4 The DHHS Program Integrity Unit may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

5.3.4.4.1 MFCU or other law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;

5.3.4.4.2 Other available remedies are available to the MCO, after DHHS approves the remedies that more effectively or quickly protect Medicaid funds;

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5.3.4.4.3 The MCO determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, there is no longer a credible allegation of fraud and that the suspension should be removed.

5.3.4.4.3.1. The MCO shall review evidence submitted by the Provider and submit it with a recommendation to DHHS.

5.3.4.4.3.2. DHHS shall direct the MCO to continue, reduce or remove the payment suspension within thirty (30) calendar days of having received the evidence;

5.3.4.4.4 Member access to items or services would be jeopardized by a payment suspension because of either of the following:

5.3.4.4.4.1. An individual or entity is the sole community physician or the sole source of essential specialized services in a community; or

5.3.4.4.4.2. The individual or entity serves a large number of Members within a federal HRSA designated a medically underserved area;

5.3.4.4.5 MFCU or law enforcement declines to certify that a matter continues to be under investigation; or

5.3.4.4.6 DHHS determines that payment suspension is not in the best interests of the Medicaid program.

5.3.4.5 The MCO shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

5.3.4.5.1 Details of payment suspensions that were imposed in whole or in part; and

5.3.4.5.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.

5.3.4.6 If the MCO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of fraud without good cause, and DHHS directed the MCO to suspend payments, DHHS may impose liquidated damages.

5.3.4.7 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery

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belongs exclusively to the State, and the MCO and any involved Subcontractor have no claim to any portion of such recovery.

5.3.4.8 Furthermore, the MCO is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the State for all criminal, civil and administrative action recoveries undertaken by any government entity, including but not limited to all claims the MCO or its Subcontractor(s) has or may have against any entity or individual that directly or indirectly receives funds under this Agreement, including but not limited to any health care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other Provider in the design, manufacture, Marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DME, or other health care related products or services.

5.3.4.8.1 For the purposes of this Section of the Agreement, "subrogation" means the right of any State government entity or local law enforcement to stand in the place of the MCO or client in the collection against a third party.

5.3.4.9 Any funds recovered and retained by a government entity shall be reported to the actuary to consider in the rate-setting process.

5.3.5 Investigations

5.3.5.1 The MCO and its Subcontractors shall cooperate with all State and federal agencies that investigate fraud, waste and abuse.

5.3.5.2 The MCO shall ensure its Subcontractors and any other contracted entities are contractually required to also participate fully with any State or federal agency or their contractors.

5.3.5.3 The MCO and its Subcontractors shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable State or federal agency (e.g., MFCU, DHHS, OIG, and CMS).

5.3.5.4 The MCO and its Subcontractors shall comply with any and all directives resulting from State or federal agency investigations.

5.3.5.5 The MCO and its Subcontractors shall maintain all records, documents and claim or encounter data for Members, Providers and Subcontractors who are under investigation by any State or federal agency in accordance with retention rules or until the investigation is complete and the case is closed by the investigating State or federal agency.

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5.3.5.6 The MCO shall provide any data access or detail records upon written request from DHHS for any potential fraud, waste and abuse investigation, Provider or claim audit, or for MCO oversight review.

5.3.5.6.1 The additional access shall be provided within three (3) business days of the request.

5.3.5.7 The MCO and its Subcontractors shall request a refund from a third-party payor, Provider or Subcontractor when an investigation indicates that such a refund is due.

5.3.5.7.1 These refunds shall be reported to DHHS as Overpayments.

5.3.5.8 DHHS shall conduct investigations related to suspected Provider fraud, waste and abuse cases, and reserves the right to pursue and retain recoveries for all claims (regardless of paid date) to a Provider with a paid date older than four (4) months for which the MCO has not submitted a request to open and for which the MCO continued to pursue the case. The State shall notify the MCO of any investigation it intends to open prior to contacting the Provider.

5.3.6 Reporting

5.3.6.1 Annual Fraud Prevention Report

5.3.6.1.1 The MCO shall submit an annual summary (the "Fraud Prevention Report") that shall document the outcome and scope of the activities performed under Section 5.3 (Program Integrity).

5.3.6.1.2 The annual Fraud Prevention summary shall include, at a minimum, the following elements, in accordance with Exhibit O:

5.3.6.1.2.1. The name of the person and department responsible for submitting the Fraud Prevention Report;

5.3.6.1.2.2. The date the report was prepared;

5.3.6.1.2.3. The date the report is submitted;

5.3.6.1.2.4. A description of the SIU;

5.3.6.1.2.5. Cumulative Overpayments identified and recovered;

5.3.6.1.2.6. Investigations initiated, completed, and referred;

5.3.6.1.2.7. Analysis of the effectiveness of the activities performed; and

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5.3.6.1.2.8. Other information in accordance with Exhibit O.

5.3.6.1.3 As part of this report, the MCO shall submit to DHHS the Overpayments it recovered, certified by its CFO that this information is accurate to the best of his or her information, knowledge, and belief, as required by Exhibit O. [42 CFR 438.606]

5.3.6.2 Reporting Member Fraud

5.3.6.2.1 The MCO shall notify DHHS of any cases in which the MCO believes there is a serious likelihood of Member fraud by sending a secure email to the DHHS Special Investigation Unit.

5.3.6.2.2 The MCO is responsible for investigating Member fraud, waste and abuse and referring Member fraud to DHHS. The MCO shall provide initial allegations, investigations and resolutions of Member fraud to DHHS.

5.3.6.3 Termination Report

5.3.6.3.1 The MCO shall submit to DHHS a monthly Termination Report including Providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related program integrity involuntary termination; Provider terminations for convenience; and Providers who self-terminated.

5.3.6.3.2 The report shall be completed using the DHHS template.

5.3.6.4 Other Reports

5.3.6.4.1 The MCO shall submit to DHHS demographic changes that may impact eligibility (e.g., Address, etc.).

5.3.6.4.2 The MCO shall report at least annually to DHHS, and as otherwise required by this Agreement, on their recoveries of Overpayments. [42 CFR 38.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)]

5.3.7 Access to Records, On-Site Inspections and Periodic Audits

5.3.7.1 As an integral part of the MCO's program integrity function, and in accordance with 42 CFR 455 and 42 CFR 438, the MCO shall provide DHHS program integrity staff (or its designee), real time access to all of the MCO electronic encounter and claims data (including DHHS third-party liability) from the MCO's current claims reporting system.

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5.3.7.2 The MCO shall provide DHHS with the capability to access accurate, timely, and complete data as specified in Section 4.18.2 (Claims Quality Assurance Program).

5.3.7.3 [Amendment #10:] ~~Upon request,~~ The MCO and the MCO's Providers and Subcontractors shall permit DHHS, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and the MCO's Providers and Subcontractors premises at any time during normal business hours to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and its Providers and Subcontractors. When reasonable, such access shall be sought during normal business hours.

5.3.7.4 The MCO and its Providers and Subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring or evaluation.

5.3.7.5 Copies of records and documents shall be made at no cost to the requesting agency. [42 CFR 438.3(h)]; 42 CFR 455.21(a)(2); 42 CFR 431.107(b)(2)]. A record includes, but is not limited to:

5.3.7.5.1 Medical records;

5.3.7.5.2 Billing records;

5.3.7.5.3 Financial records;

5.3.7.5.4 Any record related to services rendered, and quality, appropriateness, and timeliness of such service;

5.3.7.5.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and

5.3.7.5.6 Any record of an MCO-paid claim or encounter, or an MCO-denied claim or encounter.

5.3.7.6 Upon request, the MCO, its Provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate DHHS, MFCU or other State or federal agencies.

5.3.7.7 DHHS, CMS, MFCU, the OIG, the Comptroller General, or any other authorized State or federal agency or duly authorized representative shall be permitted to inspect the premises, physical

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facilities, and equipment where Medicaid-related activities are conducted at any time. [42 CFR 438.3(h)]

5.3.7.8 The MCO and its Subcontractors shall be subject to on-site or offsite reviews by DHHS and shall comply within fifteen (15) business days with any and all DHHS documentation and records requests.

5.3.7.8.1 Documents shall be furnished by the MCO or its Subcontractors at the MCO's expense.

5.3.7.9 The right to inspect and audit any records or documents of the MCO or any Subcontractor shall extend for a period of ten (10) years from the final date of this Agreement's contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.3.7.10 DHHS shall conduct, or contract for the conducting of, periodic audits of the MCO no less frequently than once every three (3) years, for the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO. [42 CFR 438.602(e)]

5.3.7.10.1 This shall include, but not be limited to, any records relevant to the MCO's obligation to bear the risk of financial losses or services performed or payable amounts under the Agreement.

5.3.8 Transparency

5.3.8.1 DHHS shall post on its website, as required by 42 CFR 438.10(c)(3), the following documents and reports:

5.3.8.1.1 The Agreement;

5.3.8.1.2 The data at 42 CFR 438.604(a)(5) where DHHS certifies that the MCO has complied with the Agreement requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 CFR 438.206;

5.3.8.1.3 The name and title of individuals included in 42 CFR 438.604(a)(6) to confirm ownership and control of the MCO, described in 42 CFR 455.104, and Subcontractors as governed by 42 CFR 438.230;

5.3.8.1.4 The results of any audits, under 42 CFR 438.602(e), and the accuracy, truthfulness, and completeness of the encounter and financial data submitted and certified by MCO; and

5.3.8.1.5 Performance metrics and outcomes.

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5.4 MCM Withhold and Incentive Program

5.4.1 [Amendment #3:] Beginning July 1, 2020, DHHS shall institute a withhold arrangement through which an actuarially sound percentage of the MCO's risk adjusted Capitation Payment will be recouped from the MCO and distributed among the MCOs participating in the MCM program on the basis of meeting targets specified in the DHHS Withhold and Incentive Program Policy.

5.4.1.1 [Amendment #3:] For the September 2019 to June 2020 contract year, DHHS shall waive the quality withhold provisions of the Agreement due to the impact of the COVID-19 Public Health Emergency. All MCOs shall receive 100% of the quality withhold.

5.4.2 [Amendment #5:] DHHS shall issue MCM Withhold and Incentive Program Guidance by August 1st each year and/or at other times as determined by DHHS. [Amendment #4:] DHHS shall, as often as annually, issue MCM Withhold and Incentive Program Guidance within ninety (90) calendar days of the start of the Plan Year, by August 1st each year.

5.4.3 Pursuant to 42 CFR 438.6 (b)(3), this withhold arrangement shall :

5.4.3.1 [Amendment #5:] Intentionally left blank.

5.4.3.1.1 Be for a fixed period of time and performance is measured during the rating period under the Agreement in which the withhold arrangement is applied;

5.4.3.1.2 Not be renewed automatically;

5.4.3.1.3 Be made available to both public and private contractors under the same terms of performance;

5.4.3.1.4 Not condition MCO participation in the withhold arrangement on the MCO entering into or adhering to intergovernmental transfer agreements; and

5.4.3.1.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.3.2 The MCO shall not receive incentive payments in excess of five percent (5%) of the approved Capitation Payments attributable to the Members or services covered by the incentive arrangements.

5.4.3.3 Pursuant to 42 CFR 438.6(b)(2), this incentive arrangement shall:

5.4.3.3.1 Be for a fixed period of time and performance is measured during the rating period under the Agreement in which the withhold arrangement is applied;

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5.4.3.3.2 Not be renewed automatically;

5.4.3.3.3 Be made available to both public and private contractors under the same terms of performance;

5.4.3.3.4 Not condition MCO participation in the incentive arrangement on the MCO entering into or adhering to intergovernmental transfer Agreements; and

5.4.3.3.5 Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the NH MCM Quality Strategy.

5.4.4 [Amendment #4:] Any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period.

~~5.4.4.1 [Amendment #9:] [Amendment #8:] Intentionally left blank. Insofar as the withhold incentive is capped at one hundred five percent (105%) of approved Capitation Payments, and the design of the Withhold and Incentive Program is to maintain withhold funds in the program, should there be a remaining amount in withhold funds within the program, additional incentives shall be available through performance metrics determined by the State so that all funds will be disbursed before the end of the contract term in accordance with separate guidance.~~

5.4.5 [Amendment #9:] [Amendment #8:] Insofar as the withhold incentive is capped at one hundred five percent (105%) of approved Capitation Payments, and the design of the Withhold and Incentive Program is to maintain withhold funds in the program for actuarial soundness, should there be a remaining amount in withheld funds within the program, additional incentives shall be available through performance metrics determined by the State so that all funds will be disbursed before the end of the contract term in accordance with separate guidance.

5.4.5.1 [Amendment #9:] Such incentives may include performance of activities in support of the Department's efforts to manage Member medical assistance eligibility redeterminations tied to the COVID-19 Public Health Emergency.

5.4.5.1.1 [Amendment #9:] [Amendment #8:] 4.10.8.1.4 The MCO shall be eligible for a SFY 2023 withhold capitation credit up to one-half percent (.5%) based on Members who have completed their redeterminations between July 1, 2022 through December 31, 2022 as described in the MCM Withhold and Incentive Program Guidance.

5.4.5.1.2 [Amendment #9:] The MCO shall be eligible for a maximum withhold capitation credit for the SFY 2023 period up to one-half percent (.5%) based on Members who have completed their

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redeterminations between January 1, 2023 through June 30, 2023 as described in the MCM Withhold and Incentive Guidance.

5.4.5.1.2.1. [Amendment #10:] The MCO shall be eligible for a maximum withhold capitation credit for the July 1, 2023 through August 31, 2024 rating period up to 0.15% based on Members who have completed their redeterminations between July 1, 2023 through October 31, 2023 as described in the MCM Withhold and Incentive Guidance.

5.4.5.1.3 [Amendment #9:] The MCO shall be eligible for additional monetary incentives from unearned withhold related to the plan's COVID-19 Public Health Emergency Member redetermination efforts as described in the MCM Withhold and Incentive Program Guidance.

5.4.5.2 [Amendment #10:] The MCO may be eligible for additional monetary incentives from the unearned withhold funds related to performance of activities to enhance care management and administrative practices including, but not limited to: fraud, waste, and abuse; medication reviews; polypharmacy; substance use disorder; and opioid treatment provider oversight and compliance as described in separate guidance.

5.5 Remedies

5.5.1 Reservation of Rights and Remedies

5.5.1.1 The Parties acknowledge and agree that a material default or breach in this Agreement shall cause irreparable injury to DHHS.

5.5.1.2 The MCO acknowledges that failure to comply with provisions of this Agreement may, at DHHS's sole discretion, result in the assessment of liquidated damages, termination of the Agreement in whole or in part, and/or imposition of other sanctions as set forth in this Agreement and as otherwise available under State and federal law.

5.5.1.3 In the event of any claim for default or breach of this Agreement, no provision of this Agreement shall be construed, expressly or by implication, as a waiver by the State to any existing or future right or remedy available by law.

5.5.1.4 Failure of the State to insist upon the strict performance of any term or condition of this Agreement or to exercise or delay the exercise of any right or remedy provided in the Agreement or by law, or the acceptance of (or payment for) materials, equipment or

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services, shall not release the MCO from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the State to insist upon the strict performance of this Agreement.

5.5.1.5 In addition to any other remedies that may be available for default or breach of the Agreement, in equity or otherwise, the State may seek injunctive relief against any threatened or actual breach of this Agreement without the necessity of proving actual damages.

5.5.1.6 The State reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as a result of any threatened or actual breach.

5.5.1.7 The remedies specified in this Section of the Agreement shall apply until the failure is cured or a resulting dispute is resolved in the MCO's favor.

5.5.2 Liquidated Damages

5.5.2.1 DHHS may perform an annual review to assess if the liquidated damages set forth in Exhibit N (Liquidated Damages Matrix) align with actual damages and/or with DHHS's strategic aims and areas of identified non-compliance, and update Exhibit N (Liquidated Damages Matrix) as needed.

5.5.2.2 DHHS and the MCO agree that it shall be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event the MCO fails to maintain the required performance standards within this Section during this Agreement.

5.5.2.3 The parties agree that the liquidated damages as specified in this Agreement and set forth in Exhibit N, and as updated by DHHS, are reasonable.

5.5.2.4 Assessment of liquidated damages shall be in addition to, not in lieu of, such other remedies that may be available to DHHS.

5.5.2.5 To the extent provided herein, DHHS shall be entitled to recover liquidated damages for each day, incidence or occurrence, as applicable, of a violation or failure.

5.5.2.6 The liquidated damages shall be assessed based on the categorization of the violation or non-compliance and are set forth in Exhibit N (Liquidated Damages Matrix).

5.5.2.7 The MCO shall be subject to liquidated damages for failure to comply in a timely manner with all reporting requirements in accordance with Exhibit O.

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5.5.3 Suspension of Payment

5.5.3.1 Payment of Capitation Payments may be suspended at DHHS's sole discretion when the MCO fails:

5.5.3.1.1 To cure a default under this Agreement to DHHS's satisfaction within thirty (30) calendar days of notification;

5.5.3.1.2 To implement a CAP addressing violations or non-compliance; and

5.5.3.1.3 To implement an approved Program Management Plan.

5.5.3.2 Upon correction of the deficiency or omission, Capitation Payments shall be reinstated.

5.5.4 Intermediate Sanctions

5.5.4.1 DHHS shall have the right to impose intermediate sanctions as set forth in 42 CFR Section 438.702(a), which include:

5.5.4.1.1 Civil monetary penalties (DHHS shall not impose any civil monetary penalty against the MCO in excess of the amounts set forth in 42 CFR 438.704(c), as adjusted);

5.5.4.1.2 Temporary management of the MCO;

5.5.4.1.3 Permitting Members to terminate enrollment without cause;

5.5.4.1.4 Suspending all new enrollment;

5.5.4.1.5 Suspending payments for new enrollment; and

5.5.4.1.6 Agreement termination.

5.5.4.2 DHHS shall impose intermediate sanctions if DHHS finds that the MCO acts or fails to act as follows:

5.5.4.2.1 Fails to substantially provide Medically Necessary services to a Member that the MCO is required to provide services to by law and/or under its Agreement with DHHS.

5.5.4.2.2 DHHS may impose a civil monetary penalty of up to \$25,000 for each failure to provide services, and may also:

5.5.4.2.2.1. Appoint temporary management for the MCO,

5.5.4.2.2.2. Grant Members the right to disenroll without cause,

5.5.4.2.2.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies

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the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.2.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(1); 42 CFR 438.702(a); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.3 Imposes premiums or charges on Members that are in excess of those permitted in the Medicaid program, in which case, the State may impose a civil monetary of up to \$25,000 or double the amount of the excess charges (whichever is greater). The State may also:

5.5.4.2.3.1. Appoint temporary management to the MCO,

5.5.4.2.3.2. Grant Members the right to disenroll without cause,

5.5.4.2.3.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.3.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; [42 CFR 438.700(b)(2); 42 CFR 438.702(a); 42 CFR 438.704(c); sections 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii) of the Social Security Act]

5.5.4.2.4 Discriminates among Members on the basis of their health status or need for health services, in which case, DHHS may impose a civil monetary penalty of up to one hundred thousand dollars (\$100,000) for each determination by DHHS of discrimination. DHHS may impose a civil monetary penalty of up to fifteen thousand dollars (\$15,000) for each individual the MCO did not enroll because of a discriminatory practice, up to the one hundred thousand dollar (\$100,000) maximum. DHHS may also:

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- 5.5.4.2.4.1. Appoint temporary management to the MCO,
- 5.5.4.2.4.2. Grant Members the right to disenroll without cause,
- 5.5.4.2.4.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or
- 5.5.4.2.4.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.700(b)(3); 42 CFR 438.702(a); 42 CFR 438.704(b)(2) and (3); sections 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii) & (iv) of the Social Security Act]
- 5.5.4.2.5 Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care Provider, in which case, DHHS may impose a civil monetary penalty of up to \$25,000 for each instance of misrepresentation. DHHS may also:
 - 5.5.4.2.5.1. Appoint temporary management to the MCO,
 - 5.5.4.2.5.2. Grant Members the right to disenroll without cause,
 - 5.5.4.2.5.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or
 - 5.5.4.2.5.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]
- 5.5.4.2.6 Misrepresents or falsifies information that it furnishes to CMS or to DHHS, in which case, DHHS may impose a civil monetary

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penalty of up to one hundred thousand dollars (\$100,000) for each instance of misrepresentation. DHHS may also:

5.5.4.2.6.1. Appoint temporary management to the MCO,

5.5.4.2.6.2. Grant Members the right to disenroll without cause,

5.5.4.2.6.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.6.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.2.7 Fails to comply with the Medicare Physician Incentive Plan requirements, in which case, DHHS may impose a civil monetary penalty of up to \$25,000 for each failure to comply. DHHS may also:

5.5.4.2.7.1. Appoint temporary management to the MCO,

5.5.4.2.7.2. Grant Members the right to disenroll without cause,

5.5.4.2.7.3. Suspend all new enrollments to the MCO after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act, and/or

5.5.4.2.7.4. Suspend payments for new enrollments to the MCO until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. [42 CFR 438.702(a); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B);

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1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.3 DHHS shall have the right to impose civil monetary penalty of up to \$25,000 for each distribution if DHHS determines that the MCO has distributed directly, or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by DHHS or that contain false or materially misleading information. [42 CFR 438.700(c); 42 CFR 438.704(b)(1); sections 1932(e)(1)(A); 1932(e)(2)(A)(i) of the Social Security Act]

5.5.4.4 DHHS shall have the right to terminate this Agreement and enroll the MCO's Members in other MCOs if DHHS determines that the MCO has failed to either carry out the terms of this Agreement or meet applicable requirements in Sections 1905(t), 1903(m), and 1905(t) 1932 of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]

5.5.4.5 DHHS shall grant Members the right to terminate MCO enrollment without cause when an MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438. [42 CFR 438.706(b) - (d); section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.4.6 DHHS shall only have the right to impose the following intermediate sanctions when DHHS determines that the MCO violated any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations:

5.5.4.6.1 Grant Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll immediately;

5.5.4.6.2 Provide notice to Members of DHHS's intent to terminate the Agreement;

5.5.4.6.3 Suspend all new enrollment, including default enrollment, after the date the HHS Secretary or DHHS notifies the MCO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act; and

5.5.4.6.4 Suspend payment for Members enrolled after the effective date of the sanction and until CMS or DHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

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5.5.4:6.5 [42 CFR 438.700; 42 CFR 438.702(a); 42 CFR 438.704; 42 CFR 438.706(b); 42 CFR 438.722(a)-(b); Sections 1903(m)(5); 1932(e) of the Social Security Act]

5.5.5 Administrative and Other Remedies

5.5.5.1 At its sole discretion, DHHS may, in addition to the other Remedies described within this Section 5.5 (Remedies), also impose the following remedies:

5.5.5.1.1 Requiring immediate remediation of any deficiency as determined by DHHS;

5.5.5.1.2 Requiring the submission of a CAP;

5.5.5.1.3 Suspending part of or all new enrollments;

5.5.5.1.4 Suspending part of the Agreement;

5.5.5.1.5 Requiring mandated trainings; and/or

5.5.5.1.6 Suspending all or part of Marketing activities for varying lengths of time.

5.5.5.2 Temporary Management

5.5.5.2.1 DHHS, at its sole discretion, shall impose temporary management when DHHS finds, through onsite surveys, Member or other complaints, financial status, or any other source:

5.5.5.2.1.1. There is continued egregious behavior by the MCO;

5.5.5.2.1.2. There is substantial risk to Members' health;

5.5.5.2.1.3. The sanction is necessary to ensure the health of the MCO's Members in one (1) of two (2) circumstances: while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the MCO. [42 CFR 438.706(a); section 1932(e)(2)(B)(i) of the Social Security Act]

5.5.5.2.2 DHHS shall impose mandatory temporary management when the MCO repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438.

5.5.5.2.3 DHHS shall not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines, in its sole discretion, that the MCO

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can ensure the sanctioned behavior shall not reoccur. [42 CFR 438.706(b)-(d); Section 1932(e)(2)(B)(ii) of the Social Security Act]

5.5.6 Corrective Action Plan

5.5.6.1 If requested by DHHS, the MCO shall submit a CAP within five (5) business days of DHHS's request, unless DHHS grants an extension to such timeframe.

5.5.6.2 DHHS shall review and approve the CAP within five (5) days of receipt.

5.5.6.3 The MCO shall implement the CAP in accordance with the timeframes specified in the CAP.

5.5.6.4 DHHS shall validate the implementation of the CAP and impose liquidated damages if it determines that the MCO failed to implement the CAP or a provision thereof as required.

5.5.7 Publication

5.5.7.1 DHHS may publish on its website, on a quarterly basis, a list of MCOs that had remedies imposed on them by DHHS during the prior quarter, the reasons for the imposition, and the type of remedy(ies) imposed.

5.5.7.2 MCOs that had their remedies reversed pursuant to the dispute resolution process prior to the posting shall not be listed.

5.5.8 Notice of Remedies

5.5.8.1 Prior to the imposition of remedies under this Agreement, except in the instance of required temporary management, DHHS shall issue written notice of remedies that shall include, as applicable, the following:

5.5.8.1.1 A citation to the law, regulation or Agreement provision that has been violated;

5.5.8.1.2 The remedies to be applied and the date the remedies shall be imposed;

5.5.8.1.3 The basis for DHHS's determination that the remedies shall be imposed;

5.5.8.1.4 The appeal rights of the MCO;

5.5.8.1.5 Whether a CAP is being requested;

5.5.8.1.6 The timeframe and procedure for the MCO to dispute DHHS's determination.

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5.5.8.1.6.1. An MCO's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damages or remedies; and

5.5.8.1.7 If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the MCO's favor. [42 CFR 438.710(a)(1)-(2)]

5.6 State Audit Rights

5.6.1 DHHS, CMS, NHID, NH Department of Justice, the OIG, the Comptroller General and their designees shall have the right to audit the records and/or documents of the MCO or the MCO's Subcontractors during the term of this Agreement and for ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later. [42 CFR 438.3(h)]

5.6.2 HHS, the HHS Secretary, (or any person or organization designated by either), and DHHS, have the right to audit and inspect any books or records of the MCO or its Subcontractors pertaining to:

5.6.2.1 The ability of the MCO to bear the risk of financial losses.

5.6.2.2 Services performed or payable amounts under the Agreement. [Section 1903(m)(2)(A)(iv) of the Social Security Act]

5.6.3 In accordance with Exhibit O, no later than forty (40) business days after the end of the State Fiscal Year, the MCO shall provide DHHS a "SOC1" or a "SOC2" Type 2 report of the MCO or its corporate parent in accordance with American Institute of Certified Public Accountants, Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

5.6.4 The report shall assess the design of internal controls and their operating effectiveness. The reporting period shall cover the previous twelve (12) months or the entire period since the previous reporting period.

5.6.5 DHHS shall share the report with internal and external auditors of the State and federal oversight agencies. The SSAE 16 Type 2 report shall include:

5.6.5.1 Description by the MCO's management of its system of policies and procedures for providing services to user entities (including control objectives and related controls as they relate to the services provided) throughout the twelve (12) month period or the entire period since the previous reporting period;

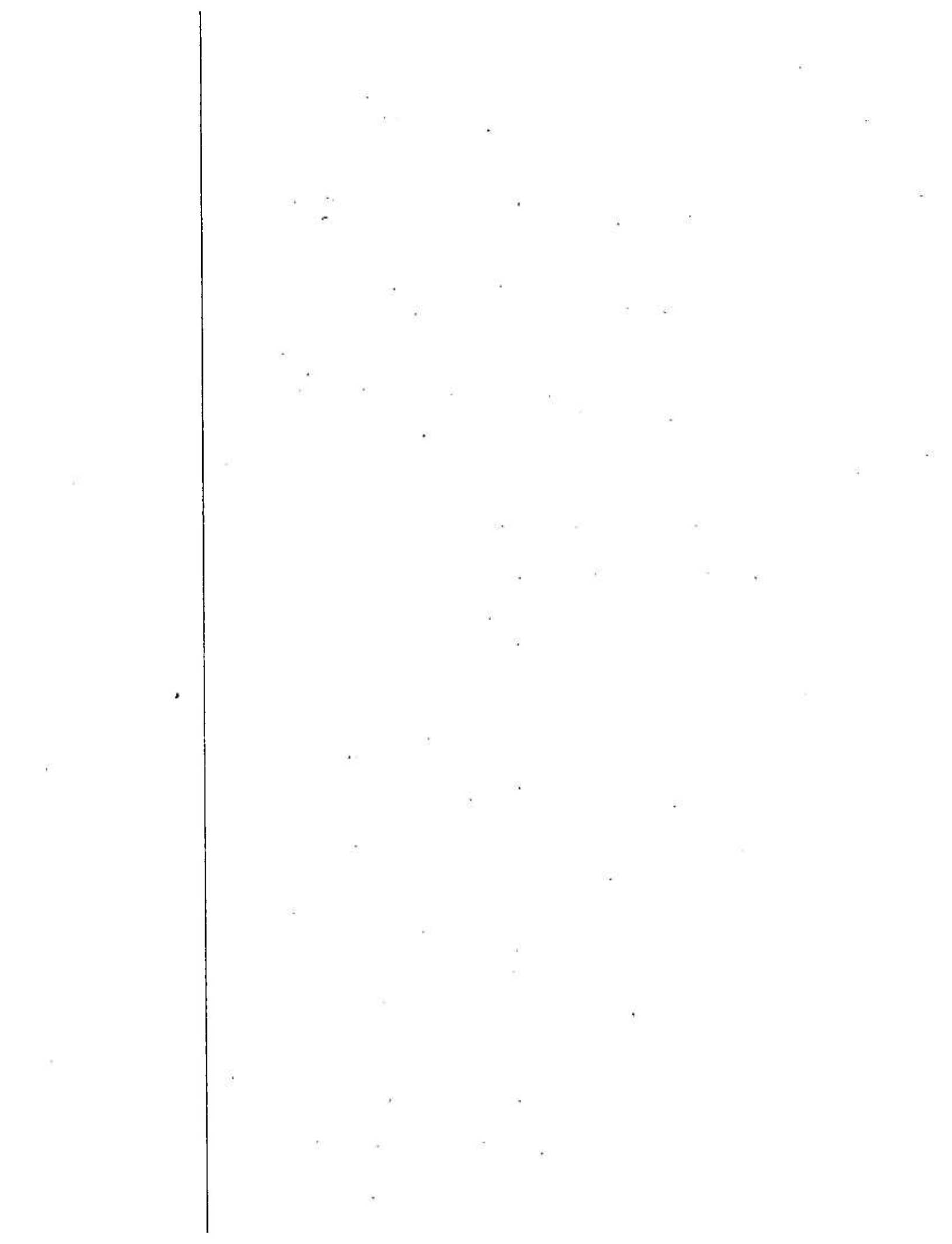
5.6.5.2 Written assertion by the MCO's management about whether:

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- 5.6.5.2.1 The aforementioned description fairly presents the system in all material respects;
- 5.6.5.2.2 The controls were suitably designed to achieve the control objectives stated in that description; and
- 5.6.5.2.3 The controls operated effectively throughout the specified period to achieve those control objectives.
- 5.6.5.3 Report of the MCO's auditor, which:
 - 5.6.5.3.1 Expresses an opinion on the matters covered in management's written assertion; and
 - 5.6.5.3.2 Includes a description of the auditor's tests of operating effectiveness of controls and the results of those tests.
- 5.6.6 The MCO shall notify DHHS if there are significant or material changes to the internal controls of the MCO.
 - 5.6.6.1 If the period covered by the most recent SSAE16 report is prior to June 30, the MCO shall additionally provide a bridge letter certifying to that fact.
- 5.6.7 The MCO shall respond to and provide resolution of audit inquiries and findings relative to the MCO Managed Care activities.
- 5.6.8 DHHS may require monthly plan oversight meetings to review progress on the MCO's Program Management Plan, review any ongoing CAPs and review MCO compliance with requirements and standards as specified in this Agreement.
- 5.6.9 The MCO shall use reasonable efforts to respond to DHHS oral and written correspondence within one (1) business day of receipt.
- 5.6.10 The MCO shall file annual and interim financial statements in accordance with the standards set forth below.
- 5.6.11 Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the National Association of Insurance Commissioners, annual audited financial statements that have been audited by an independent Certified Public Accountant. [42 CFR 438.3(m)]
 - 5.6.11.1 Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.
- 5.6.12 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by NHID.



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5.6.13 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners.

5.7 Dispute Resolution Process

5.7.1 Informal Dispute Process

5.7.1.1 In connection with any action taken or decision made by DHHS with respect to this Agreement, within thirty (30) calendar days following the action or decision, the MCO may protest such action or decision by the delivery of a written notice of protest to DHHS and by which the MCO may protest said action or decision and/or request an informal hearing with the NH Medicaid Director ("Medicaid Director").

5.7.1.2 The MCO shall provide DHHS with a written statement of the action being protested, an explanation of its legal basis for the protest, and its position on the action or decision.

5.7.1.3 The Director shall determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s).

5.7.1.3.1 The presentation and discussion of the disputed issue(s) shall be informal in nature.

5.7.1.4 The Director shall provide written notice of the time, format and location of the presentations.

5.7.1.5 At the conclusion of the presentations, the Director shall consider all evidence and shall render a written recommendation, subject to approval by the DHHS Commissioner, as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentation.

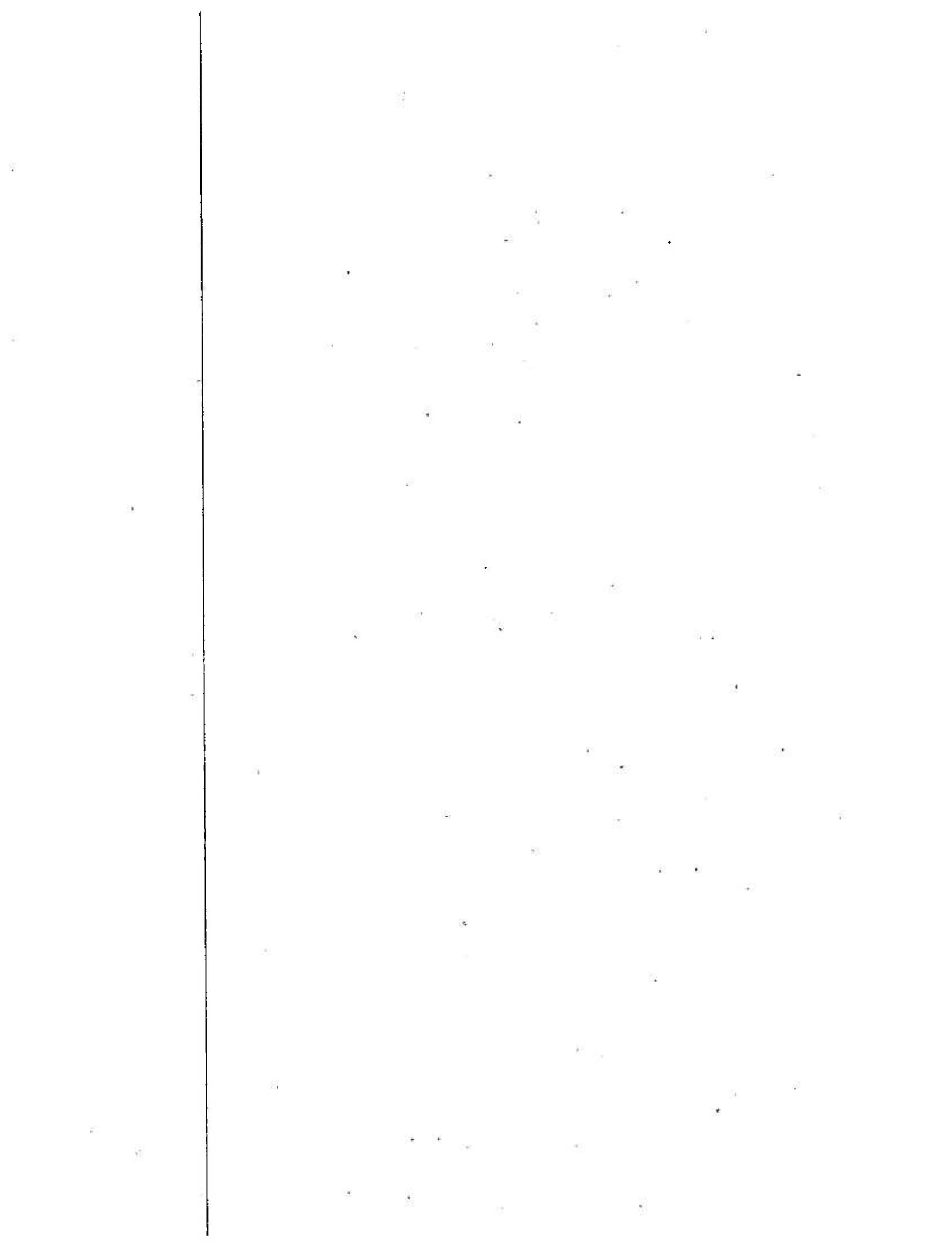
5.7.1.6 The Director may appoint a designee to hear the matter and make a recommendation.

5.7.2 Hearing

5.7.2.1 In the event of a termination by DHHS, pursuant to 42 CFR Section 438.708, DHHS shall provide the MCO with notice and a pre-termination hearing in accordance with 42 CFR Section 438.710.

5.7.2.2 DHHS shall provide written notice of the decision from the hearing.

5.7.2.3 In the event of an affirming decision at the hearing, DHHS shall provide the effective date of the Agreement termination.



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5.7.2.4 In the event of an affirming decision at the hearing, DHHS shall give the Members of the MCO notice of the termination, and shall inform Members of their options for receiving Medicaid services following the effective date of termination. [42 CFR 438.710(b); 42 CFR 438.710(b)(2)(i) - (iii); 42 CFR 438.10]

5.7.3 No Waiver

5.7.3.1 The MCO's exercise of its rights under Section 5.5.1 (Reservation of Rights and Remedies) shall not limit, be deemed a waiver of, or otherwise impact the Parties' rights or remedies otherwise available under law or this Agreement, including but not limited to the MCO's right to appeal a decision of DHHS under RSA chapter 541-A, if applicable, or any applicable provisions of the NH Code of Administrative Rules, including but not limited to Chapter He-C 200 Rules of Practice and Procedure.

6 FINANCIAL MANAGEMENT

6.1 Financial Standards

6.1.1 In compliance with 42 CFR 438.116, the MCO shall maintain a minimum level of capital as determined in accordance with NHID regulations, to include RSA Chapter 404-F, and any other relevant laws and regulations.

6.1.2 The MCO shall maintain a risk-based capital ratio to meet or exceed the NHID regulations, and any other relevant laws and regulations.

6.1.3 With the exception of payment of a claim for a medical product or service that was provided to a Member, and that is in accordance with a written agreement with the Provider, the MCO may not pay money or transfer any assets for any reason to an affiliate without prior approval from DHHS, if any of the following criteria apply:

6.1.3.1 Risk-based capital ratio was less than two (2) for the most recent year filing, per RSA 404-F:14 (III); and

6.1.3.2 The MCO was not in compliance with the NHID solvency requirement.

6.1.4 The MCO shall notify DHHS within ten (10) calendar days when its agreement with an independent auditor or actuary has ended and seek approval of, and the name of the replacement auditor or actuary, if any from DHHS.

6.1.5 The MCO shall maintain current assets, plus long-term investments that can be converted to cash within seven (7) calendar days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

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6.1.6 The MCO shall submit data on the basis of which DHHS has the ability to determine that the MCO has made adequate provisions against the risk of insolvency.

6.1.7 The MCO shall inform DHHS and NHID staff by phone and by email within five (5) business days of when any key personnel learn of any actual or threatened litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the MCO to perform under this Agreement.

6.1.7.1 [Amendment #9:] The MCO shall prohibit clawback business arrangements whereby Pharmacy Benefit Managers (PBM) reimburse network pharmacies an initial drug reimbursement amount and dispensing fee, and subsequently the PBM receives remuneration for a portion of that fee that is unreported to the Department and its actuary.

6.2 Capitation Payments

6.2.1 Capitation payments made by DHHS and retained by the MCO shall be for Medicaid-eligible Members. [42 CFR 438.3(c)(2)]

6.2.1.1 [Amendment #5:] Capitation rates for the Term through June 30, 2020 are shown in Exhibit B (Capitation Rates).

6.2.1.2 For each of the subsequent years of the Agreement, actuarially sound per Member, per month capitated rates shall be paid as calculated and certified by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

6.2.1.3 Any rate adjustments shall be subject to the availability of State appropriations.

6.2.1.4 [Amendment #6:] Capitation rates shall be based on generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board. [42 CFR 457.10]

6.2.2 In the event the MCO incurs costs in the performance of this Agreement that exceed the capitation payments, the State and its agencies are not responsible for those costs and shall not provide additional payments to cover such costs.

6.2.3 The MCO shall report to DHHS within sixty (60) calendar days upon identifying any capitation or other payments in excess of amounts provided in this Agreement. [42 CFR 438.608(c)(3)]

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6.2.4 The MCO and DHHS agree that the capitation rates in Exhibit B (Capitation Rates) may be adjusted periodically to maintain actuarial soundness as determined by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

6.2.5 The MCO shall submit data on the basis of which the State certifies the actuarial soundness of capitation rates to an MCO, including base data that is generated by the MCO. [42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)]

6.2.6 When requested by DHHS, the MCO shall submit Encounter Data, financial data, and other data to DHHS to ensure actuarial soundness in development of the capitated rates, or any other actuarial analysis required by DHHS or State or federal law.

6.2.7 The MCO's CFO shall submit and concurrently certify to the best of his or her information, knowledge, and belief that all data and information described in 42 CFR 438.604(a), which DHHS uses to determine the capitated rates, is accurate. [42 CFR 438.606]

6.2.8 The MCO has responsibility for implementing systems and protocols to maximize the collection of TPL recoveries and subrogation activities. The capitation rates are calculated net of expected MCO recoveries.

6.2.9 DHHS shall make a monthly payment to the MCO for each Member enrolled in the MCO's plan as DHHS currently structures its capitation payments.

6.2.9.1 [Amendment #6:] Beginning contract year July 1, 2021, Specifically, the monthly capitation payments for all standard Medicaid Members shall be made retrospectively with a one month three month plus five (5) business day lag as soon as DHHS system modifications can be completed (for example, coverage for September 1, 2021 July 1, 2019 shall be paid by the 5th business day in October 2021 2019).

6.2.9.2 Capitation payments for all Granite Advantage Members shall be made before the end of each month of coverage.

6.2.10 Capitation rate cell is determined based on the Member characteristics as of the earliest date of Member plan enrollment span(s) within the month.

6.2.11 Capitation rate does not change during the month, regardless of Member changes (e.g., age), unless the Member's plan enrollment is terminated and the Member is re-enrolled resulting in multiple spans within the month.

6.2.12 The capitation rates shall be risk adjusted for purposes of this Agreement in an actuarially sound manner on a quarterly basis and certified by DHHS' actuary.

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6.2.12.1 [Amendment #10:] [Amendment #8:] [Amendment #6:] [Amendment #5:] The September 2019 to August 31, 2024~~June 2024-2022-2023~~ capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.

~~[Amendment #2:] The September 2019 to June 2020 capitation rates shall use an actuarially sound prospective risk adjustment model to adjust the rates for each participating MCO.~~

6.2.12.1.1 [Amendment #5:] [Amendment #2:] The risk adjustment process shall use the most recent version of the CDPS+Rx model to assign scored individuals to a demographic category and disease categories based on their medical claims and drug utilization during the study period. The methodology shall also incorporate a custom risk weight related to the cost of opioid addiction services. Scored individuals are those with at least six months of eligibility and claims experience in the base data. The methodology shall exclude diagnosis codes related to radiology and laboratory services to avoid including false positive diagnostic indicators for tests run on an individual. Additionally, each scored member with less than 12 months of experience in the base data period shall also be assigned a durational adjustment to compensate for missing diagnoses due to shorter enrollment durations, similar to a missing data adjustment.

6.2.12.1.2 [Amendment #2:] Each unscored member shall be assigned a demographic-only risk weight instead of receiving the average risk score for each MCO's scored members in the same rate cell. The risk adjustment methodology shall also incorporate a specific adjustment to address cost and acuity differences between the scored and unscored populations, which shall be documented by a thorough review of historical data for those populations based on generally accepted actuarial techniques.

6.2.12.1.3 [Amendment #2:] Members shall be assigned to MCOs and rate cells using the actual enrollment by MCO in each quarter to calculate risk scores in order to capture actual membership growth for each MCO.

6.2.12.1.4 [Amendment #5:] The capitation rates for the Non-Medically Frail population shall use an actuarially sound concurrent risk adjustment model to adjust the rates for each participating MCO until sufficient historical data is available to use a prospective risk adjustment model.

6.2.12.1.4.1. [Amendment #7:] Effective January 1, 2021, risk adjustment for the Non-Medically Frail

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population shall be performed on a prospective basis as described in this Section 6.2.12.1.

~~6.2.12.2 [Amendment #9:]~~~~[Amendment #8:]~~ Intentionally left blank. For the period July 1, 2022 through June 30, 2023, capitation rates shall be subject to a retroactive acuity adjustment methodology to account for the change in enrollment during the public health emergency continuous enrollment unwind as authorized in writing by the Centers for Medicare and Medicaid Services Division of Managed Care Policy on May 11, 2022, and described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for this Amendment #8.

6.2.12.3 [Amendment #10:] For the rating period July 1, 2023 through August 31, 2024 capitation rates include a preliminary acuity adjustment based on DHHS's intended PHE unwind process and a detailed redetermination schedule to estimate the percentage of Members expected to leave the Medicaid program for each redetermination cohort as explained in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for this rating period Amendment. The adjustment will be updated for Amendment #11 capitation rates, as appropriate.

6.2.13 DHHS reserves the right to terminate or implement the use of a risk adjustment process for all or specific eligibility categories or services if it is determined to be necessary to do so to maintain actuarially sound rates or as a result of credibility considerations of a population's size as determined by DHHS's actuary.

6.2.14 Capitation adjustments are processed systematically each month by DHHS's MMIS.

6.2.15 DHHS shall make systematic adjustments based on factors that affect rate cell assignment or plan enrollment.

6.2.16 If a Member is deceased, DHHS shall recoup any and all capitation payments after the Member's date of death including any prorated share of a capitation payment intended to cover dates of services after the Member's date of death.

6.2.17 DHHS shall also make manual adjustments as needed, including manual adjustments for kick payments.

6.2.18 DHHS has sole discretion over the settlement process.

6.2.19 The MCO shall follow policies and procedures for the settlement process as developed by DHHS.

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6.2.20 Based on the provisions herein, DHHS shall not make any further retroactive adjustments other than those described herein or elsewhere in this agreement.

6.2.21 DHHS and the MCO agree that there is a nine (9) month limitation from the date of the capitation payment and is applicable only to retroactive capitation rate payments described herein, and shall in no way be construed to limit the effective date of enrollment in the MCO.

6.2.22 DHHS shall have the discretion to recoup payments retroactively up to twenty-four (24)-months for Members whom DHHS later determines were not eligible for Medicaid during the enrollment month for which capitation payment was made.

6.2.23 For each live birth, DHHS shall make a one-time maternity kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.23.1 This payment is a global fee to cover all delivery care.

6.2.23.2 In the event of a multiple birth DHHS shall only make only one (1) maternity kick payment.

6.2.23.3 A live birth is defined in accordance with NH Vital Records reporting requirements for live births as specified in RSA 5-C.

6.2.24 For each live birth, DHHS shall make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the DOB.

6.2.24.1 This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services.

6.2.24.2 For example, the newborn kick payment shall cover all services provided in July 2019 and August 2019 for a baby born any time in July 2019.

6.2.24.3 Enrolled babies shall be covered under the MCO capitated rates thereafter.

6.2.25 Different rates of newborn kick payments may be employed by DHHS, in its sole discretion, to increase actuarial soundness.

6.2.25.1 [Amendment #1:] For the period beginning September 1, 2019, two (2) newborn kick payments shall be employed, one (1) for newborns with NAS and one (1) for all other newborns. [Base Contract:] For the period beginning July 1, 2019, two (2) newborn kick payments shall be employed, one (1) for newborns with NAS and one (1) for all other newborns.

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6.2.25.2 Each type of payment is distinct and only one payment is made per newborn.

6.2.26 The MCO shall submit information on maternity and newborn events to DHHS, and shall follow written policies and procedures, as developed by DHHS, for receiving, processing and reconciling maternity and newborn payments.

6.2.27 Payment for behavioral health rate cells shall be determined based on a Member's CMH Program or CMH Provider behavioral certification level as supplied in an interface to DHHS's MMIS by the MCO.

6.2.27.1 The CMH Program or CMH Provider behavioral certification level is based on a Member having had an encounter in the last six (6) months.

6.2.27.2 Changes in the certification level for a Member shall be reflected as of the first of each month and does not change during the month.

6.2.28 [Amendment #1:] Beginning September 1, 2019, after the completion of each Agreement year, an actuarially sound withhold percentage of each MCO's risk adjusted capitation payment net of directed payments to the MCO shall be calculated as having been withheld by DHHS. On the basis of the MCO's performance, as determined under DHHS's MCM Withhold and Incentive Guidance, unearned withhold in full or in part is subject to recoupment by DHHS to be used to finance an MCO incentive pool.
~~[Base Contract:] Beginning July 1, 2019, after the completion of each Agreement year, an actuarially sound withhold percentage of each MCO's risk adjusted capitation payment net of directed payments to the MCO shall be calculated as having been withheld by DHHS. On the basis of the MCO's performance, as determined under DHHS's MCM Withhold and Incentive Guidance, unearned withhold in full or in part is subject to recoupment by DHHS to be used to finance an MCO incentive pool.~~

6.2.29 Details of the MCM Withhold and Incentive Program are described in MCM Withhold and Incentive Program Guidance provided by DHHS as indicated in Section 5.4 (MCM Withhold and Incentive Payment Program).

6.2.30 DHHS shall inform the MCO of any required program revisions or additions in a timely manner.

6.2.31 DHHS may adjust the rates to reflect these changes as necessary to maintain actuarial soundness.

6.2.32 In the event an enrolled Medicaid Member was previously admitted as a hospital inpatient and is receiving continued inpatient hospital services on the first day of coverage with the MCO, the MCO shall receive the applicable capitation payment for that Member.

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6.2.33 The entity responsible for coverage of the Member at the time of admission as an inpatient (either DHHS or another MCO) shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

6.2.34 [Amendment #8:] Beginning July 1, 2022, DHHS shall only make a monthly capitation payment to the MCO for a Member aged 21–64 receiving inpatient treatment in an IMD, as defined in 42 CFR 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment, or as has been otherwise permitted by CMS through a waiver obtained from CMS. [42 CFR 438.6(e)]

6.2.35 Unless MCOs are exempted, through legislation or otherwise, from having to make payments to the NH Insurance Administrative Fund (Fund) pursuant to RSA 400-A:39, DHHS shall reimburse MCO for MCO's annual payment to the Fund on a supplemental basis within 30 days following receipt of invoice from the MCO and verification of payment by the NHID.

6.2.36 [Amendment #5:] [Amendment #2:] For any Member with claims exceeding five hundred thousand dollars (\$500,000) or other attachment point described in this section for the fiscal year, after applying any third party insurance offset, DHHS shall reimburse fifty percent (50%) of the amount over the greater of five hundred thousand dollars (\$500,000) or the attachment point after all claims have been recalculated based on the DHHS fee schedule for the services and pro-rated for the contract year, as appropriate.

6.2.36.1 [Amendment #5:] The stop-loss attachment point of \$500,000 shall be indexed annually at a rate of 3.0% from its inception in SFY 2016 and rounded to the nearest \$1,000.

6.2.36.1.1 [Amendment #5:] For the period July 1, 2020 through June 30, 2021, the attachment point shall be \$580,000.

6.2.36.1.2 [Amendment #6:] For the period July 1, 2021 through June 30, 2022, the attachment point shall be \$597,000.

6.2.36.1.3 [Amendment #8:] For the period July 1, 2022 through June 30, 2023, the attachment point shall be \$615,000.

6.2.36.1.4 [Amendment #10:] For the period July 1, 2023 through August 31, 2024, the attachment point shall be \$740,000.

6.2.36.2 [Amendment #5] For a Member whose services may be projected to exceed the attachment point five hundred thousand

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dollars ~~(\$500,000)~~ in total MCO claims, the MCO shall advise DHHS in writing.

6.2.36.3 [Amendment #5:] Prior approval from the Medicaid Director is required for subsequent services provided to the Member.

6.2.36.4 [Amendment #5:] ~~[Amendment #2:] 6.2.36.1.4~~ Hospital inpatient and hospital outpatient services provided by Boston Children's Hospital are exempt from stop-loss protections referenced in this section.

6.2.37 [Amendment #2:] DHHS shall implement a budget neutral-risk pool for services provided at Boston Children's Hospital in order to better allocate funds based on MCO-specific spending for these services. Inpatient and outpatient facility services provided at Boston Children's Hospital qualify for risk pool calculation.

6.2.38 [Amendment #2:] Beginning September 1, 2019, the gene therapy medication Zolgensma used to treat spinal muscular atrophy (SMA) shall be carved-out of the at-risk services under the MCM benefit package. As such, costs for Zolgensma and other carved-out medications shall not be considered under the various risk mitigation provisions of the Agreement.

6.2.38.1 [Amendment #5:] For the contract period January 1, 2021 through June 30, 2021, the cost of the COVID-19 vaccine and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

6.2.38.2 [Amendment #10:] [Amendment #8:] [Amendment #6:] For the contract period July 1, 2023~~2022~~ through August 31, 2024~~the end of the federal Public Health Emergency Period June 30, 2022~~, the cost of the COVID-19 vaccines and the administration thereof shall be under a non-risk payment arrangement as further described in guidance.

6.2.38.3 [Amendment #8:] For the contract period July 1, 2022 through June 30, 2023, the cost of COVID vaccine counseling for children and youth ages 0 up to 21 years shall be under a non-risk payment arrangement as further described in guidance.

6.2.38.4 [Amendment #9:] Beginning January 1, 2023, high cost gene therapy and biological medications shall be under a non-risk payment arrangement and excluded under the various risk mitigation provisions of the Agreement as described in separate guidance.

6.2.39 [Amendment #4:] Beginning September 1, 2019, should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which

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CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. [Amendment #3:] Beginning September 1, 2019, should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must not implement that part after the effective date of the loss of program authority.

6.2.39.1 [Amendment #4:] The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. [Amendment #3:] The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law.

6.2.39.2 [Amendment #4:] If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work. [Amendment #3:] If the MCO received capitation payments that included costs specific to a program or activity no longer authorized by law prior to the effective date of the loss of authority for work that would be performed after that effective date, the state must adjust those capitation payments to ensure that previous reimbursement of costs specific to the program or activity no longer authorized is returned to the state and that costs specific to the program or activity no longer authorized are no longer paid by the state after the effective date of the loss of program authority.

6.2.39.3 [Amendment #4:] If the state paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. [Amendment #3:] Capitation payments received prior to the effective date of loss of program authority that included costs for work specific to the program or activity that is no longer authorized, but that was performed prior to that effective date, may be retained by the managed care plan and need not be returned to the state.

6.2.39.4 [Amendment #4:] However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

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6.2.40 [Amendment #4:] To account for attributable costs related to the HB 4 January 2021 provider rate increase and unknown development of COVID-19 costs, a January 2021 rate refresh shall be conducted.

6.2.41 [Amendment #10:] [Amendment #8:] For the July 1, 20232022 through August 31, 2024June 30, 2023 rating period, DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG codes 880-887, except as described in Section 6.2.41.3 below.

[Amendment #7:] For the July 1, 2021 through June 30, 2022 rating period, DHHS shall make a one-time kick payment to the MCO for each Member psychiatric admission stay with DRG code 880-887, and the State Plan rate for Hampstead Hospital.

6.2.41.1 [Amendment #6:] The kick payment shall be specific to the corresponding Peer Groups established by DHHS. Separate kick payments exist for Peer Group 01 and 07, Peer Group 02, Peer Group 06, and Peer Group 09.

6.2.41.2 [Amendment #6:] Psychiatric admissions for dually eligible Members are not subject to the kick payment and shall be paid out of the capitation rates.

6.2.41.3 [Amendment #8:] [Amendment #6:] Psychiatric admissions for adult Members at New Hampshire Hospital and Hampstead Hospital are not subject to the kick payment and shall be paid out of the MCO's capitation rates.

6.2.42 [Amendment #7:] Intentionally left blank [Amendment #6:] Effective July 1, 2021, DHHS shall initially pay capitation rates based on the December 2021 Public Health Emergency (PHE) scenario of the PHE ending December 2021 or later.

6.2.42.1 [Amendment #7:] Intentionally left blank [Amendment #6:] In the event the PHE ends prior to October 1, 2021, DHHS shall retroactively pay capitation rates developed under the September 2021 scenario as described in the actuarial rate report for the period July 1, 2021 through June 30, 2022.

6.3 [Amendment #6:] Medical Loss Ratio Reporting and Settlement

6.3.1 Minimum Medical Loss Ratio Performance and Rebate Requirements

6.3.1.1 The MCO shall meet a minimum MLR of eighty-five percent (85%) or higher.

6.3.1.2 In the event the MCO's MLR for any single reporting year is below the minimum of the eighty-five percent (85%) requirement, the MCO shall provide to DHHS a rebate, no later than sixty (60)

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calendar days following DHHS notification, that amounts to the difference between the total amount of Capitation Payments received by the MCO from DHHS multiplied by the required MLR of eighty-five percent (85%) and the MCO's actual MLR. [42 CFR 438.8(j); 42 CFR 438.8(c)]

6.3.1.3 If the MCO fails to pay any rebate owed to DHHS in accordance with the time periods set forth by DHHS, in addition to providing the required rebate to DHHS, the MCO shall pay DHHS interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher, on the total amount of the rebate.

6.3.2. Calculation of the Medical Loss Ratio

6.3.2.1 The MCO shall calculate and report to DHHS the MLR for each MLR reporting year, in accordance with 42 CFR 438.8 and the standards described within this Agreement. [42 CFR 438.8(a)].

6.3.2.2 The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)). [42 CFR 438.8 (d)-(f)].

6.3.2.3 Each MCO expense shall be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense shall be pro-rated between the two types of expenses.

6.3.2.3.1 Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on a pro rata basis. [42 CFR 438.8(g)(1)(i)-(ii)]

6.3.2.4 Expense allocation shall be based on a generally accepted accounting method that is extended to yield the most accurate results.

6.3.2.4.1 Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

6.3.2.4.2 Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to other entities. [42 CFR 438.8(g)(2)(i)-(iii)].

6.3.2.5 The MCO may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

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6.3.2.5.1 The credibility adjustment, if included, shall be added to the reported MLR calculation prior to calculating any remittances.

6.3.2.5.2 The MCO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

6.3.2.5.3 If the MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. [42 CFR 438.8(h)(1)-(3)]

6.3.3 Medical Loss Ratio Reporting

6.3.3.1 The MCO shall submit MLR summary reports quarterly to DHHS in accordance with Exhibit O [42 CFR 438.8(k)(2); 42 CFR 438.8(k)(1)].

6.3.3.2 The MLR summary reports shall include all information required by 42 CFR 438.8(k) within nine (9) months of the end of the MLR reporting year, including:

6.3.3.2.1 Total incurred claims;

6.3.3.2.2 Expenditures on quality improvement activities;

6.3.3.2.3 Expenditures related to activities compliant with the program integrity requirements;

6.3.3.2.4 Non-claims costs;

6.3.3.2.5 Premium revenue;

6.3.3.2.6 Taxes;

6.3.3.2.7 Licensing fees;

6.3.3.2.8 Regulatory fees;

6.3.3.2.9 Methodology(ies) for allocation of expenditures;

6.3.3.2.10 Any credibility adjustment applied;

6.3.3.2.11 The calculated MLR;

6.3.3.2.12 Any remittance owed to the State, if applicable;

6.3.3.2.13 A comparison of the information reported with the audited financial report;

6.3.3.2.14 A description of the aggregate method used to calculate total incurred claims; and

6.3.3.2.15 The number of Member months. [42 CFR 438.8(k)(1)(i)-(xiii); 42 CFR 438.608(a)(1)-(5); 42 CFR 438.608(a)(7)-(8); 42 CFR 438.608(b); 42 CFR 438.8(i)]

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6.3.3.3 The MCO shall attest to the accuracy of the summary reports and calculation of the MLR when submitting its MLR summary reports to DHHS. [42 CFR 438.8(n); 42 CFR 438.8(k)]

6.3.3.4 Such summary reports shall be based on a template developed and provided by DHHS within sixty (60) calendar days of the Program Start Date. [42 CFR 438.8(a)]

6.3.3.5 The MCO shall in its MLR summary reports aggregate data for all Medicaid eligibility groups covered under this Agreement unless otherwise required by DHHS. [42 CFR 438.8(i)]

6.3.3.6 The MCO shall require any Subcontractor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCO within one hundred and eighty (180) calendar days or the end of the MLR reporting year or within thirty (30) calendar days of a request by the MCO, whichever comes sooner, regardless of current contract limitations, to calculate and validate the accuracy of MLR reporting. [42 CFR 438.8(k)(3)]

6.3.3.7 In any instance in which DHHS makes a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to DHHS, the MCO shall:

6.3.3.7.1 Re-calculate the MLR for all MLR reporting years affected by the change; and

6.3.3.7.2 Submit a new MLR report meeting the applicable requirements. [42 CFR 438.8(m); 42 CFR 438.8(k)]

6.3.3.8 The MCO and its Subcontractors (as applicable) shall retain MLR reports for a period of no less than ten (10) years.

6.3.4 [Amendment #6:] Minimum and Maximum Medical Loss Ratios

6.3.4.1 [Amendment #10:] [Amendment #9:] [Amendment #8:] [Amendment #6:] For the period July 1, 2023-2024 through August 31, 2024 June 30, 2022-2023, the target MLR for at-risk services is 90.98%90.8% for Standard Medicaid and 89.9%90.21% for GAHCP based on the SFY-2023 projected enrollment distribution for the rating period. Please note, each program's target MLR may change in future rate amendments as a result of changes to underlying assumptions, such as enrollment projections, emerging utilization experience, and the-retroactive acuity adjustments, if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period. The minimum MLR is set on a program-wide basis for each major

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population, such that the maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs below: shall limit the MCO's gain to four percent (4%). The maximum MLR shall limit the MCO's loss to two three and one-half percent (3.5-2.5%) over the target MLR.

6.3.4.1.1 [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] The minimum MLR is set on a program-wide basis for each major population, such that the maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). The minimum MLR shall be ~~88.2~~ 88.343% for the Standard Medicaid population and ~~87.4~~ 87.476% for the GAHCP population.

6.3.4.1.2 [Amendment #10:] [Amendment #9] [Amendment #8:] [Amendment #6:] The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that the MCOs will have a maximum loss of 2.0%. Based on the target MLRs, the maximum MLR shall be 94.343% ~~shall be 94.2~~ ~~94.3%~~ for the Standard Medicaid population and ~~93.4~~ 93.476% for the GAHCP population.

6.3.4.1.2.1. [Amendment #9] [Amendment #8:] The final maximum and minimum MLRs for Standard Medicaid and GAHCP shall be updated for the final retroactive acuity factor and any other changes implemented in the ~~expected January 2023~~ contract amendment, as applicable.

6.3.4.1.3 [Amendment #6:] The settlement shall be done separately for the Standard Medicaid and GAHCP populations.

6.3.4.1.4 [Amendment #9:] [Amendment #8:] [Amendment #6:] Other MCM program risk mitigation provisions shall apply prior to the minimum and maximum MLR calculation risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment, and retrospective acuity adjustment), if applicable, as described in the State's capitation rate letter, exhibits, and certification filed with the Centers for Medicare and Medicaid Services for the period.

6.3.4.1.5 [Amendment #8:] [Amendment #6:] The numerator of the MCO's actual MLR shall include all payments made to providers, such as fee-for-service payments, sub-capitation payments, incentive payments, and settlement payments. The numerator of

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each MCO's actual MLR shall not include costs related to quality improvement expenses or fraud, waste and abuse prevention.

6.3.4.1.6 [Amendment #6:] Payments and revenue related to directed payments and premium taxes shall be excluded from the numerator and denominator of the MCO's actual MLR.

6.3.4.1.7 [Amendment #6:] Any incentive payments made to higher-performing MCOs as part of the Withhold Program shall not impact the minimum or maximum MLR provision of the contract.

6.3.4.1.8 [Amendment #6:] The timing of the minimum and maximum MLR settlement shall occur after the contract year is closed and substantial paid claims runout is available.

6.3.4.1.8.1. [Amendment #8:] Payments related to the Withhold and Incentive Program shall be excluded from the minimum and maximum MLR settlement.

6.4 Financial Responsibility for Dual-Eligible Members

6.4.1 [Amendment #7:] For Medicare Part A crossover claims and Medicare Part B crossover claims billed on the UB-04, the MCO shall pay the patient responsibility amount (deductible and coinsurance) for covered services. For the period July 1, 2021 through June 30, 2022, the minimum MLR shall limit the MCO's gain to four percent (4%). The maximum MLR shall limit the MCO's loss to three and one-half percent (3-1/2%) over the target MLR.

6.4.2 For Part B crossover claims billed on the CMS-1500, the MCO shall pay the lesser of:

6.4.2.1 [Amendment #7:] The patient responsibility amount (deductible and coinsurance) for covered services, or

6.4.2.2 The difference between the amount paid by the primary payer and the Medicaid allowed amount.

6.4.3 For both Medicare Part A and Part B claims, if the Member responsibility amount is "0" then the MCO shall make no payment.

6.5 Medical Cost Accruals

6.5.1 The MCO shall establish and maintain an actuarially sound process to estimate Incurred But Not Reported (IBNR) claims, services rendered for which claims have not been received.

6.6 Audits

6.6.1 The MCO shall permit DHHS or its designee(s) and/or the NHID to inspect and audit any of the financial records of the MCO and its Subcontractors.

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6.6.2 There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. [42 CFR 438.6(g), SMM 2087.7; 42 CFR 434.6(a)(5)]

6.6.3 The MCO shall file annual and interim financial statements in accordance with the standards set forth in this Section 6 (Financial Management) of this Agreement.

6.6.3.1 This Section shall supersede any conflicting requirements in Exhibit C (Special Provisions) of this Agreement.

6.6.4 Within one hundred and eighty (180) calendar days or other mutually agreed upon date following the end of each calendar year during this Agreement, the MCO shall file, in the form and content prescribed by the NAIC, annual audited financial statements that have been audited by an independent Certified Public Accountant.

6.6.4.1 Financial statements shall be submitted in either paper format or electronic format, provided that all electronic submissions shall be in PDF format or another read-only format that maintains the documents' security and integrity.

6.6.5 The MCO shall also file, within seventy-five (75) calendar days following the end of each calendar year, certified copies of the annual statement and reports as prescribed and adopted by the NHID.

6.6.6 The MCO shall file within sixty (60) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

6.7 Member Liability

6.7.1 The MCO shall not hold MCM Members liable for:

6.7.1.1 The MCO's debts, in the event of the MCO's insolvency;

6.7.1.2 The Covered Services provided to the Member, for which the State does not pay the MCO;

6.7.1.3 The Covered Services provided to the Member, for which the State, or the MCO does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement; or

6.7.1.4 Payments for Covered Services furnished under an agreement, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the MCO provided those services directly. [42 CFR 438.106(a)-(c);

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section 1932(b)(6) of the Social Security Act; 42 CFR 438.3(k); 42 CFR 438.230]

6.7.2 The MCO shall provide assurances satisfactory to DHHS that its provision against the risk of insolvency is adequate to ensure that Medicaid Members shall not be liable for the MCO's debt if the MCO becomes insolvent. [42 CFR 438.116(a)]

6.7.3 Subcontractors and Referral Providers may not bill Members any amount greater than would be owed if the entity provided the services directly [Section 1932(b)(6) of the SSA; 42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230; 42 CFR 438.204(a); SMDL 12/30/97].

6.7.4 The MCO shall cover services to Members for the period for which payment has been made, as well as for inpatient admissions up until discharge during insolvency. [SMM 2086.6B]

6.7.5 The MCO shall meet DHHS's solvency standards for private health maintenance organizations, or be licensed or certified by DHHS as a risk-bearing entity. [Section 1903(m)(1) of the Social Security Act; 42 CFR 438.116(b)]

6.8 Denial of Payment

6.8.1 Payments provided for under the Agreement shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS.

6.8.2 CMS may deny payment to the State for new Members if its determination is not timely contested by the MCO. [42 CFR 438.726(b); 42 CFR 438.730(e)(1)(ii)]

6.9 Federal Matching Funds

6.9.1 Federal matching funds are not available for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services. [42 CFR 431.55(h) and 42 CFR 438.808; 1128(b)(8) and Section 1903(i)(2) of the SSA; SMDL 12/30/97]

6.9.2 Payments made to such Providers are subject to recoupment from the MCO by DHHS.

6.10 Health Insurance Providers Fee

6.10.1 The Affordable Care Act imposed an annual fee on health insurance Providers beginning in 2014 ("Annual Fee").

6.10.1.1 [Amendment #6:] The Further Consolidated Appropriations Act, 2020, repealed the annual fee on health insurance Providers for calendar years beginning after December 31, 2020; therefore, calendar year 2020 shall be the last fee year.

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6.10.2 The MCO is responsible for a percentage of the Annual Fee for all health insurance Providers as determined by the ratio of MCO's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.

6.10.3 To the extent such fees exist and DHHS is legally obligated to pay such fees under Federal law:

6.10.3.1 The State shall reimburse the MCO for the amount of the Annual Fee specifically allocable to the premiums paid during the Term of this Agreement for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee").

6.10.3.2 The MCO's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount the MCO or the MCO's parent receives from the United States Internal Revenue Service.

6.10.3.3 The State shall provide reimbursement no later than one hundred and twenty (120) business days following its review and acceptance of the MCO's Adjusted Fee.

6.10.3.4 To claim reimbursement for the MCO's Adjusted Fee, the MCO shall submit a certified copy of its full Annual Fee assessment within sixty (60) business days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this Agreement.

6.10.3.5 The MCO shall also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums, and any other data deemed necessary by the State to validate the reimbursement amount.

6.10.3.6 These materials shall be submitted under the signatures of either its Financial Officer or CEO/Executive Director, certifying the accuracy, truthfulness and completeness of the data provided.

6.11 Third Party Liability

6.11.1 NH Medicaid shall be the payor of last resort for all Covered Services in accordance with federal regulations.

6.11.2 The MCO shall develop and implement policies and procedures to meet its obligations regarding TPL. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.3 DHHS and the MCO shall cooperate in implementing cost avoidance and cost recovery activities.

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6.11.4 The MCO shall be responsible for making every reasonable effort to determine the liable third party to pay for services rendered and cost avoid and/or recover any such liabilities from the third party.

6.11.5 DHHS shall conduct two (2) TPL policy and procedure audits of the MCO and its Subcontractors per Agreement year.

6.11.5.1 Noncompliance with CAPs issued due to deficiencies may result in liquidated damages as outlined in Exhibit N.

6.11.6 The MCO shall have one (1) dedicated contact person for DHHS for TPL.

6.11.7 DHHS and/or its actuary shall identify a market-expected median TPL percentage amount and deduct an appropriate amount from the gross medical costs included in the DHHS Capitation Payment rate setting process.

6.11.8 All cost recovery amounts, even those greater than identified in the rate cells, shall be retained by the MCO.

6.11.9 The MCO and its Subcontractors shall comply with all regulations and State laws related to TPL, including but not limited to:

6.11.9.1 42 CFR 433.138;

6.11.9.2 42 CFR 433.139; and

6.11.9.3 RSA 167:14-a.

6.11.10 Cost Avoidance

6.11.10.1 The MCO and its Subcontractors performing claims processing duties shall be responsible for cost avoidance through the Coordination of Benefits (COB) relating to federal and private health insurance resources, including but not limited to Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1396a(a)(25) plans and workers compensation.

6.11.10.2 The MCO shall establish claims edits and deny payment of claims when active Medicare or active private insurance exists at the time the claim is adjudicated and the claim does not reflect payment from the other payer.

6.11.10.3 The MCO shall deny payment on a claim that has been denied by Medicare or private insurance when the reason for denial is the Provider or Member's failure to follow prescribed procedures including, but not limited to, failure to obtain Prior Authorization or timely claim filing.

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6.11.10.4 The MCO shall establish claim edits to ensure claims with Medicare or private insurance denials are properly denied by the MCO.

6.11.10.5 The MCO shall make its own independent decisions about approving claims for payment that have been denied by the private insurance or Medicare if either:

6.11.10.5.1 The primary payor does not cover the services and the MCO does; or

6.11.10.5.2 The service was denied as not Medically Necessary and the Provider followed the dispute resolution and/or Appeal Process of the private insurance or Medicare and the denial was upheld.

6.11.10.6 If a claim is denied by the MCO based on active Medicare or active private insurance, the MCO shall provide the Medicare or private insurance information to the Provider.

6.11.10.7 To ensure the MCO is cost avoiding, the MCO shall implement a file transfer protocol between DHHS MMIS and the MCO's MCIS to receive and send Medicare and private insurance information and other information as required pursuant to 42 CFR 433.138.

6.11.10.8 The MCO shall implement a nightly file transfer protocol with its Subcontractors to ensure Medicare, private health insurance, ERISA, 29 U.S.C. 1396a(a)(25) plans, and workers compensation policy information is updated and utilized to ensure claims are properly denied for Medicare or private insurance.

6.11.10.9 The MCO shall establish, and shall ensure its Subcontractors utilize, monthly electronic data matches with private insurance companies (Medical and pharmacy) that sell insurance in the State to obtain current and accurate private insurance information for their Members. This provision may be satisfied by a contract with a third-party vendor to the MCO or its Subcontractors. Notwithstanding the above, the MCO remains solely responsible for meeting the requirement.

6.11.10.10 Upon audit, the MCO shall demonstrate with written documentation that good faith efforts were made to establish data matching agreements with insurers selling in the State who have refused to participate in data matching agreements with the MCO.

6.11.10.11 The MCO shall maintain the following private insurance data within their system for all insurance policies that a Member may have and include for each policy:

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- 6.11.10.11.1 Member's first and last name;
- 6.11.10.11.2 Member's policy number;
- 6.11.10.11.3 Member's group number, if available;
- 6.11.10.11.4 Policyholder's first and last name;
- 6.11.10.11.5 Policy coverage type to include at a minimum:
 - 6.11.10.11.5.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below).
 - 6.11.10.11.5.2. Hospital coverage,
 - 6.11.10.11.5.3. Pharmacy coverage,
 - 6.11.10.11.5.4. Dental coverage, and
 - 6.11.10.11.5.5. Vision Coverage;
- 6.11.10.11.6 Begin date of insurance; and
- 6.11.10.11.7 End date of insurance (when terminated).
- 6.11.10.12 The MCO shall submit any new, changed, or terminated private insurance data to DHHS through file transfer on a weekly basis.
- 6.11.10.13 The MCO shall not cost avoid claims for preventive pediatric services (including EPSDT), that is covered under the Medicaid State Plan per 42 CFR 433.139(b)(3).
- 6.11.10.14 The MCO shall pay all preventive pediatric services and collect reimbursement from private insurance after the claim adjudicates.
- 6.11.10.15 The MCO shall pay the Provider for the Member's private insurance cost sharing (Copays and deductibles) up to the MCO Provider contract allowable.
- 6.11.10.16 On a quarterly basis, the MCO shall submit a cost avoidance summary, as described in Exhibit O.
- 6.11.10.17 This report shall reflect the number of claims and dollar amount avoided by private insurance and Medicare for all types of coverage as follows:
 - 6.11.10.17.1 Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or other health coverage not listed below);
 - 6.11.10.17.2 Hospital coverage;

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- 6.11.10.17.3 Pharmacy coverage;
- 6.11.10.17.4 Dental coverage; and
- 6.11.10.17.5 Vision coverage.

6.11.11 Post Payment Recovery

6.11.11.1 Definitions

6.11.11.1.1 Pay and Chase means recovery of claims paid in which Medicare or private insurance was not known at the time the claim was adjudicated.

6.11.11.1.2 Subrogation means personal injury, liability insurance, automobile/home insurance, or accident indemnity insurance where a third party may be liable.

6.11.11.2 Pay and Chase Private Insurance

6.11.11.2.1 If private insurance exists for services provided and paid by the MCO, but was not known by the MCO at time the claim was adjudicated, then the MCO shall pursue recovery of funds expended from the private insurance company.

6.11.11.2.2 The MCO shall submit quarterly recovery reports, in accordance with Exhibit O.

6.11.11.2.3 These reports shall reflect detail and summary information of the MCO's collection efforts and recovery from Medicare and private insurance for all types of coverage as follows:

6.11.11.2.3.1. Medical coverage (including, mental health, DME, Chiropractic, skilled nursing, home health, or another other health coverage not listed below);

6.11.11.2.3.2. Hospital coverage;

6.11.11.2.3.3. Pharmacy coverage;

6.11.11.2.3.4. Dental coverage; and

6.11.11.2.3.5. Vision Coverage.

6.11.11.2.4 [Amendment #5:] The MCO shall have eight (8) months from the original paid date to initiate recovery of recover funds from private insurance.

6.11.11.2.4.1. [Amendment #5:] If funds have not been recovered by that date, the claim is not on the Exhibit O TPLCOB.02 or TPLCOB.03 report for recovery within 8 months of the paid date, DHHS has the sole and

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exclusive right to pursue, collect, and retain funds from private insurance.

6.11.11.2.4.2. [Amendment #5:] If a recovery is closed on the Exhibit O TPLCOB.02 or TPLCOB.03 report for any reason, DHHS has the right to initiate collections from private insurance, after the MCO closure, and retain any funds recovered.

6.11.11.2.5 The MCO shall treat funds recovered from private insurance as offsets to the claims payments by posting within the claim system.

6.11.11.2.5.1. The MCO shall post all payments to claim level detail by Member.

6.11.11.2.5.2. Any Overpayment by private insurance can be applied to other claims not paid or covered by private insurance for the same Member.

6.11.11.2.5.3. Amounts beyond a Member's outstanding claims shall be returned to the Member.

6.11.11.2.6 The MCO and its Subcontractors shall not deny or delay approval of otherwise covered treatment or services based on TPL considerations, nor bill or pursue collection from a Member for services.

6.11.11.2.7 The MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of TPL is established at the time the claim is adjudicated. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.11.3 Subrogation Recoveries

6.11.11.3.1 The MCO shall be responsible for pursuing recoveries of claims paid when there is an accident or trauma in which there is a third party liable, such as automobile insurance, malpractice, lawsuit, including class action lawsuits.

6.11.11.3.2 The MCO shall act upon any information from insurance carriers or attorneys regarding potential subrogation cases. The MCO shall be required to seek Subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines.

6.11.11.3.3 The MCO shall establish detailed policies and procedures for determining, processing, and recovering funds based on accident and trauma Subrogation cases.

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6.11.11.3.4 The MCO shall submit its policies and procedures, including those related to their case tracking system as described in Section 6.11.11.3.6, to DHHS for approval during the readiness review process. The MCO shall have in its policies and procedures, at a minimum, the following:

6.11.11.3.4.1. The MCO shall establish a paid claims review process based on diagnosis and trauma codes to identify claims that may constitute an accident or trauma in which there may be a liable third party.

6.11.11.3.4.2. The claims required to be identified, at a minimum, should include ICD-10 diagnosis codes related to accident or injury and claims with an accident trauma indicator of "Y".

6.11.11.3.4.3. The MCO shall present a list of ICD-10 diagnostic codes to DHHS for approval in identifying claims for review.

6.11.11.3.4.4. DHHS reserves the right to require specific codes be reviewed by MCO.

6.11.11.3.4.5. The MCO shall establish a monthly process to request additional information from Members to determine if there is a liable third party for any accident or trauma related claims by establishing a questionnaire to be sent to Members.

6.11.11.3.4.6. The MCO shall submit a report of questionnaires generated and sent as described in Exhibit O.

6.11.11.3.4.7. The MCO shall establish timeframes and claim logic for determining when additional letters to Members should be sent relating to specific accident diagnosis codes and indicators.

6.11.11.3.4.8. The MCO shall respond to accident referrals and lien request within twenty-one (21) calendar days of the notice per RSA 167:14-a.

6.11.11.3.5 The MCO shall establish a case tracking system to monitor and manage Subrogation cases.

6.11.11.3.6 This system shall allow for reporting of case status at the request of DHHS, OIG, CMS, and any of their designees. The tracking system shall, at a minimum, maintain the following record:

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- 6.11.11.3.6.1. Date inquiry letter sent to Member, if applicable;
- 6.11.11.3.6.2. Date inquiry letter received back from Member, if applicable;
- 6.11.11.3.6.3. Date of contact with insurance company, attorney, or Member informing the MCO of an accident;
- 6.11.11.3.6.4. Date case is established;
- 6.11.11.3.6.5. Date of incident;
- 6.11.11.3.6.6. Reason for incident;
- 6.11.11.3.6.7. Claims associated with incident;
- 6.11.11.3.6.8. All correspondence and dates;
- 6.11.11.3.6.9. Case comments by date;
- 6.11.11.3.6.10. Lien amount and date updated;
- 6.11.11.3.6.11. Settlement amount;
- 6.11.11.3.6.12. Date settlement funds received; and
- 6.11.11.3.6.13. Date case closed.

6.11.11.3.7 The MCO shall submit Subrogation reports in accordance with Exhibit O. [42 CFR 433 Sub D; 42 CFR 447.20]

6.11.11.3.8 DHHS shall inform the MCO of any claims related to an MCO Subrogation cases.

6.11.11.3.9 The MCO shall submit to DHHS any and all information regarding the case if DHHS also has a Subrogation lien.

6.11.11.3.10 [Amendment #5:] The MCO shall coordinate with DHHS on any dual Subrogation settlement recoveries identified in writing by DHHS. DHHS claims shall be paid first in any dual Subrogation settlement.

6.11.11.3.10.1. [Amendment #5:] The MCO shall pay DHHS claims first in the event of any settlement less than the combined total MCO and DHHS lien amount.

6.11.11.3.10.2. [Amendment #5:] The MCO shall be liable for repayment to DHHS for the total DHHS lien amount in situations when DHHS informed the MCO of the State's lien in advance of the settlement, regardless of whether the DHHS lien amount exceeds the total

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settlement amount recovered when the MCO settles a subrogation case and accepts a settlement amount without written authorization from DHHS.

6.11.11.3.11 The MCO shall submit to DHHS for approval any Subrogation proposed settlement agreement that is less than eighty percent (80%) of the total lien in which the MCO intends to accept prior to acceptance of the settlement.

6.11.11.3.12 DHHS shall have twenty (20) business days to review the case once the MCO provides all relevant information as determined by DHHS to approve the settlement from date received from the MCO.

6.11.11.3.13 If DHHS does not respond within twenty (20) business days, the MCO may proceed with settlement.

6.11.11.3.14 If DHHS does not approve of the settlement agreement, then DHHS may work with the MCO and other parties on the settlement.

6.11.11.3.15 DHHS shall have exclusive rights to pursue subrogations in which the MCO does not have an active subrogation case within one hundred and eighty (180) calendar days of receiving a referral, of sending the first questionnaire as referenced in 6.11.11.3.4.5 of this Section, or of claim paid date if no action was taken since claims paid date.

6.11.11.3.16 In the event that there are outstanding Subrogation settlements at the time of Agreement termination, the MCO shall assign DHHS all rights to such cases to complete and collect on those Subrogation settlements.

6.11.11.3.17 DHHS shall retain all recoveries after Agreement termination.

6.11.11.3.18 The MCO shall treat funds recovered due to Subrogation, if not processed as part of claims, outside of the claims processing system as offsets to medical expenses for the purpose of reporting.

6.11.11.4 Medicare

6.11.11.4.1 The MCO shall be responsible for coordinating benefits for dually eligible Members, if applicable.

6.11.11.4.2 The MCO shall enter into a Coordination of Benefits Agreement (COBA) for NH with Medicare and participate in the automated crossover process. [42 CFR 438.3(t)]

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6.11.11.4.3 A newly contracted MCO shall have ninety (90) calendar days from the start of this Agreement to establish and start file transfers with COBA.

6.11.11.4.4 The MCO and its Subcontractors shall establish claims edits to ensure that:

6.11.11.4.4.1. Claims covered by Medicare part D are denied when a Member has an active Medicare part A or Medicare part B;

6.11.11.4.4.2. Claims covered by Medicare part B are denied when a Member has an active Medicare part B; and

6.11.11.4.4.3. The MCO treats Members with Medicare part C as if they had Medicare part A and Medicare part B and shall establish claims edits and deny part D for those part C Members.

6.11.11.4.5 If Medicare was not known or active at the time a claim was adjudicated but was determined active or retroactive at a later date, the MCO shall recoup funds from the Provider and require the Provider to pursue Medicare payment for all claim types except Medicare part D.

6.11.11.4.5.1. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.11.11.4.6 If Medicare was not known or active at the time a claim was submitted by a Provider to the MCO, but was determined active or retroactive subsequent to the MCO's payment of the claim, the MCO shall recoup funds from the Provider and the Provider may pursue Medicare payment, except for Medicare Part D, for all claim types, provided the claims remain within the timely filing requirements.

6.11.11.4.6.1. The MCO shall pursue collection for Medicare Part D from the Medicare Part D plan.

6.11.11.4.7 The MCO shall contact DHHS if Members' claims were denied due to the lack of active Medicare part D or Medicare part B.

6.11.11.4.8 The MCO shall pay applicable Medicare coinsurance and deductible amounts as outlined in Section 6.4 (Financial Responsibility for Dual-Eligible Members). These payments are included in the calculated Capitation Payment.

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6.11.11.4.9 The MCO shall pay any wrap around services not covered by Medicare that are services under the Medicaid State Plan Amendment and this Agreement.

6.11.11.5 Estate Recoveries

6.11.11.5.1 DHHS shall be solely responsible for estate recovery activities and shall retain all funds recovered through these activities.

6.12 **[Amendment #3:] Risk Corridors**

6.12.1 [Amendment #3:] Subject to CMS approval, DHHS shall implement a risk corridor as described in Table 1, for the September 2019 to June 2020 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

[Amendment #3:]
Table 1
 New Hampshire Department of Health and Human Services
 Medicaid Care Management Program
 [Amendment #4:] Proposed September 2019 to June 2020
 MCM Program Risk Corridor Parameters

MLR Claims Corridor	MCO Share of Gain / Loss in Corridor	DHHS Share of Gain / Loss in Corridor
Less than Target MLR - 3.5%	0%	100%
Target MLR - 3.5% to Target MLR - 2.0%	75%	25%
Target MLR - 2.0% to Target MLR + 1.5%	100%	0%
Target MLR + 1.5% to Target MLR + 3.5%	75%	25%
Greater than Target MLR + 3.5%	0%	100%

6.12.1.1 [Amendment #3:] The MCO capitation rates reflect a target medical loss ratio (MLR) which measures the projected medical service costs as a percentage of the total MCO capitation rates. The risk corridor would limit MCO gains and losses if the actual MLR is different than the target MLR.

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6.12.1.2 [Amendment #3:] The MCM program target MLR for at-risk services is 89.6% for Standard Medicaid and 88.7% for GAHCP based on the September 2019 to June 2020 projected enrollment distribution. Target MLRs will be calculated separately for each MCO based on their actual enrollment mix by rate cell.

6.12.1.3 [Amendment #3:] Table 1 summarizes the share of gains and losses relative to the target MLR for each party.

6.12.1.4 [Amendment #3:] The settlement will be done separately for the Standard Medicaid and GAHCP populations.

6.12.1.5 [Amendment #3:] Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment).

6.12.1.6 [Amendment #3:] The numerator of each MCO's actual MLR will include all payments made to providers, such as fee-for-service payments, subcapitation payments, incentive payments, and settlement payments.

6.12.1.7 [Amendment #3:] Payments and revenue related to directed payments and premium taxes will be excluded from the numerator and denominator of each MCO's actual MLR, which is consistent with the treatment of directed payments and premium taxes in federal MLR calculations.

6.12.1.8 [Amendment #3:] The 85% minimum MLR provision in the MCM contract will apply after the risk corridor settlement calculation. The 85% minimum MLR provision is adjudicated using federal MLR reporting rules, which produce a different MLR than the MLR calculated for risk corridor settlement purposes.

6.12.1.9 [Amendment #3:] The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

6.12.2 [Amendment #4:] Subject to CMS approval, DHHS shall implement a risk corridor as described in Table 1, for the July 2020 to June 2021 (SFY 2021) contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

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Amendment #10 Table 1 New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY2021 MCM Program Risk Corridor Parameters		
MLR Claims Corridor	MCO Share of Gain / Loss in Corridor	DHHS Share of Gain / Loss in Corridor
Less than Target MLR - 3.5%	0%	100%
Target MLR - 3.5% to Target MLR - 1.5%	50%	50%
Target MLR - 1.5% to Target MLR + 1.5%	100%	0%
Target MLR + 1.5% to Target MLR + 3.5%	50%	50%
Greater than Target MLR + 3.5%	0%	100%

6.12.2.1 [Amendment #4:] The MCO capitation rates reflect a target medical loss ratio (MLR) which measures the projected medical service costs as a percentage of the total MCO capitation rates. The risk corridor would limit MCO gains and losses if the actual MLR is different than the target MLR.

6.12.2.2 [Amendment #4:] The MCM program target MLR for at-risk services is 89.5% for Standard Medicaid and 88.6% for GAHCP based on the July 2020 to June 2021 projected enrollment distribution. Target MLRs will be calculated separately for each MCO based on their actual enrollment mix by rate cell.

6.12.2.3 [Amendment #4:] Table 1 summarizes the share of gains and losses relative to the target MLR for each party.

6.12.2.4 [Amendment #4:] The settlement will be done separately for the Standard Medicaid and GAHCP populations.

6.12.2.5 [Amendment #5:] Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment). [Amendment #4:] ~~Other MCM program risk mitigation provisions will apply prior to the risk corridor (i.e., Boston Children's Hospital risk pool, high cost patient stop loss arrangement, and prospective risk adjustment).~~

6.12.2.6 [Amendment #4:] The numerator of each MCO's actual MLR will include all payments made to providers, such as fee-for-service payments, subcapitation payments, incentive payments, and settlement payments.

6.12.2.7 [Amendment #4:] Payments and revenue related to directed payments and premium taxes will be excluded from the numerator and denominator of each MCO's actual MLR, which is

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consistent with the treatment of directed payments and premium taxes in federal MLR calculations.

6.12.2.8 [Amendment #4:] The 85% minimum MLR provision in the MCM contract will apply after the risk corridor settlement calculation. The 85% minimum MLR provision is adjudicated using federal MLR reporting rules, which produce a different MLR than the MLR calculated for risk corridor settlement purposes.

6.12.2.9 [Amendment #4:] The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

6.12.3 [Amendment #4:] The Granite Advantage Health Care Plan (GAHCP) risk corridor calculation shall be applied after the risk adjustment calculation.

6.12.3.1 [Amendment #4:] The timing of the risk corridor settlement will occur after the contract year is closed and substantial paid claims runout is available.

7 TERMINATION OF AGREEMENT

7.1 Termination for Cause

7.1.1 DHHS shall have the right to terminate this Agreement, in whole or in part, without liability to the State, if the MCO:

7.1.1.1 Takes any action or fails to prevent an action that threatens the health, safety or welfare of any Member, including significant Marketing abuses;

7.1.1.2 Takes any action that threatens the fiscal integrity of the Medicaid program;

7.1.1.3 Has its certification suspended or revoked by any federal agency and/or is federally debarred or excluded from federal procurement and/or non-procurement agreement;

7.1.1.4 Materially breaches this Agreement or fails to comply with any term or condition of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

7.1.1.5 Violates State or federal law or regulation;

7.1.1.6 Fails to carry out a substantive term or terms of this Agreement that is not cured within twenty (20) business days of DHHS's notice and written request for compliance;

7.1.1.7 Becomes insolvent;

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7.1.1.8 Fails to meet applicable requirements in Sections 1932, 1903 (m) and 1905(t) of the Social Security Act.; [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act]

7.1.1.9 Receives a "going concern" finding in an annual financial report or indications that creditors are unwilling or unable to continue to provide goods, services or financing or any other indication of insolvency; or

7.1.1.10 Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily under Title 11 of the U.S. Code.

7.2 Termination for Other Reasons

7.2.1 The MCO shall have the right to terminate this Agreement if DHHS fails to make agreed-upon payments in a timely manner or fails to comply with any material term or condition of this Agreement, provided that, DHHS has not cured such deficiency within sixty (60) business days of its receipt of written notice of such deficiency.

7.2.2 This Agreement may be terminated for convenience by either the MCO or DHHS as of the last day of any month upon no less than one-hundred twenty (120) business days prior written notice to the other party.

7.2.3 Notwithstanding Section 7.2.2, this Agreement may be terminated immediately by DHHS if federal financial participation in the costs hereof becomes unavailable or if State funds sufficient to fulfill its obligations of DHHS hereunder are not appropriated by the Legislature. In either event, DHHS shall give MCO prompt written notice of such termination.

7.2.4 Notwithstanding the above, the MCO shall not be relieved of liability to DHHS or damages sustained by virtue of any breach of this Agreement by the MCO.

7.2.5 Upon termination, all documents, data, and reports prepared by the MCO under this Agreement shall become the property of and be delivered to DHHS immediately on demand.

7.2.6 DHHS may terminate this Agreement, in whole or in part, and place Members into a different MCO or provide Medicaid benefits through other Medicaid State Plan Authority, if DHHS determines that the MCO has failed to carry out the substantive terms of this Agreement or meet the applicable requirements of Sections 1932, 1903(m) or 1905(t) of the Social Security Act. [42 CFR 438.708(a); 42 CFR 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act].

7.2.6.1 In such event, Section 4.7.9 (Access to Providers During Transition of Care) shall apply.

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7.3 Claims Responsibilities

7.3.1 The MCO shall be fully responsible for all inpatient care services and all related services authorized while the Member was an inpatient until the day of discharge from the hospital.

7.3.2 The MCO shall be financially responsible for all other authorized services when the service is provided on or before the last day of the Closeout Period (defined in Section 7.7.3. (Service Authorization/Continuity of Care) below, or if the service is provided through the date of discharge.

7.4 Final Obligations

7.4.1 DHHS may withhold payments to the MCO, to the reasonable extent it deems necessary, to ensure that all final financial obligations of the MCO have been satisfied. Such withheld payments may be used as a set-off and/or applied to the MCO's outstanding final financial obligations.

7.4.2 If all financial obligations of the MCO have been satisfied, amounts due to the MCO for unpaid premiums, risk, settlement, High Dollar Stop Loss, shall be paid to the MCO within one (1) year of date of termination of the Agreement.

7.5 Survival of Terms

7.5.1 Termination or expiration of this Agreement for any reason shall not release either the MCO or DHHS from any liabilities or obligations set forth in this Agreement that:

7.5.1.1 The parties have expressly agreed shall survive any such termination or expiration; or

7.5.1.2 Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any such termination or expiration, or obliges either party by law or regulation.

7.6 Agreement Closeout

7.6.1 Period

7.6.1.1 DHHS shall have the right to define the close out period in each event of termination, and such period shall take into consideration factors such as the reason for the termination and the timeframe necessary to transfer Members.

7.6.1.2 During the closeout period, the MCO shall work cooperatively with, and supply program information to, any subsequent MCO and DHHS.

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7.6.1.3 Both the program information and the working relationships between the two MCOs shall be defined by DHHS.

7.6.2 Data

7.6.2.1 The MCO shall be responsible for the provision of necessary information and records, whether a part of the MCIS or compiled and/or stored elsewhere, including but not limited to Encounter Data, to the new MCO and/or DHHS during the closeout period to ensure a smooth transition of responsibility.

7.6.2.2 The new MCO and/or DHHS shall define the information required from the MCO during this period and the time frames for submission.

7.6.2.3 All data and information provided by the MCO shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied.

7.6.2.4 The MCO shall transmit the information and records required under this Section within the time frames required by DHHS.

7.6.2.5 DHHS shall have the right, in its sole discretion, to require updates to these data at regular intervals.

7.6.2.6 The MCO shall be responsible for continued submission of data to the CHIS during and after the transition in accordance with NHID regulations.

7.6.3 Service Authorization/Continuity of Care

7.6.3.1 Effective fourteen (14) calendar days prior to the last day of the closeout period, the MCO shall work cooperatively with DHHS and/or its designee to process service authorization requests received.

7.6.3.1.1 Disputes between the MCO and DHHS and/or its designee regarding service authorizations shall be resolved by DHHS in its sole discretion.

7.6.3.2 The MCO shall give written notice to DHHS of all service authorizations that are not decided upon by the MCO within fourteen (14) calendar days prior to the last day of the closeout period.

7.6.3.2.1 Untimely service authorizations constitute a denial and are thus adverse actions [42 CFR 438.404(c)(5)].

7.6.3.3 The Member has access to services consistent with the access they previously had, and is permitted to retain their current Provider for the period referenced in Section 4.7.9 (Access to

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Providers During Transitions of Care) for the transition timeframes if that Provider is not in the new MCO's network of Participating Providers.

7.6.3.4 The Member shall be referred to appropriate Participating Providers.

7.6.3.5 The MCO that was previously serving the Member, fully and timely complies with requests for historical utilization data from the new MCO in compliance with State and federal law.

7.6.3.6 Consistent with State and federal law, the Member's new Provider(s) are able to obtain copies of the Member's medical records, as appropriate.

7.6.3.7 Any other necessary procedures as specified by the HHS Secretary to ensure continued access to services to prevent serious detriment to the Member's health or reduce the risk of hospitalization or institutionalization.

7.6.3.8 DHHS shall make any other transition of care requirements publically available.



New Hampshire Medicaid Care Management Contract Medicaid Care Management Services

Exhibit B Method and Conditions Precedent to Payment - Amendment #10

1. Capitation Payments/Rates

This Agreement is reimbursed on a per member per month capitation rate for the Agreement term, subject to all conditions contained within Exhibit A. Accordingly, no maximum or minimum product volume is guaranteed. Any quantities set forth in this contract are estimates only. The Contractor agrees to serve all members in each category of eligibility who enroll with this Contractor for covered services. Capitation payment rates are as follows:

July 1, 2023 – August 31, 2024

Medicaid Care Management

Base Population

	Capitation Rate
Foster Care / Adoption Subsidy	\$428.42
Severely Disabled Children (DD & IHS)	1,682.15
Low Income Children - Age 0 - 11 months	404.28
Low Income Children - Age 1 - 18	197.72
Low Income Adults - Age 19+	487.49
Elderly and Disabled Adults - Age 19 - 64	1,433.61
Dual Eligibles (all dual rate cells)	278.83
Elderly and Disabled Adults - Age 65+	1,174.03
CHIP	186.44

Behavioral Health Population Rate Cells

Severe & Persistent Mental Illness: Dual	\$ 1,723.35
Severe & Persistent Mental Illness: Non Dual	2,374.70
Severe Mental Illness: Dual	1,137.10
Severe Mental Illness: Non Dual	1,666.72
Low Utilizer - Dual	684.24
Low Utilizer - Non Dual	1,650.59
SED Child - TANF and Foster Care	1,117.54

Medicaid Expansion

Medically Frail	\$1,106.91
Non-Medically Frail	483.31

Maternity/Newborn Kick Payments

Maternity kick Payment	\$ 3,385.41
Newborn kick Payment	6,762.03
Neonatal Abstinence Syndrome kick Payment	21,023.17



**New Hampshire Medicaid Care Management Contract
Medicaid Care Management Services**

Exhibit B Method and Conditions Precedent to Payment - Amendment #10

For each of the subsequent years of the Agreement, actuarially sound per Member, per month capitated rates shall be paid as calculated and certified by DHHS's actuary, subject to approval by CMS and Governor and Executive Council.

Any rate adjustments shall be subject to the availability of State appropriations.

2. Price Limitation

This Agreement is one of multiple contracts that will serve the New Hampshire Medicaid Care Management Program. The estimated member months, for the fourteen month contract period covering State Fiscal Year 2024, July 1, 2023 – June 30, 2024, and State Fiscal Year 2025 July 1, 2024 – August 31, 2024 to be served among all contracts is 2,499,560. Accordingly, the price limitation for the fourteen month contract period July 1, 2023 – August 31, 2024 among all contracts is \$ 1,209,229,580 based on the projected members per month. The full price limitation is \$ 5,928,058,454.

Questions regarding payment(s) should be addressed to:
Attn: Medicaid Finance Director
New Hampshire Medicaid Managed Care Program
129 Pleasant Street
Concord, NH 03301

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Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements Amendment #10

1. General

- 1.1. The list of deliverables in Exhibit O provides a high-level summary of what each deliverable will entail. *Please note all information is subject to revision and refinement as NH DHHS finalizes the specifications for each deliverable.*
- 1.2. The Exhibit O measures/measure sets, logs, and narrative reports shall be submitted according to the specified schedule. Submission formats shall either be the standard HEDIS submission format for HEDIS measures or as specified by NH DHHS for other measures, data tables and reports.
- 1.3. NH DHHS utilizes measures from several measure stewards, including NCQA and the Pharmacy Quality Alliance (PQA). The MCO is responsible for contracting with these entities or associated vendors as appropriate for producing deliverables.
- 1.4. To help insure the successful generation of consistent Exhibit O deliverables (both over time for each MCO and across all MCOs), the following processes will be in place.
 - 1.4.1. NH DHHS shall:
 - 1.4.1.1. Identify specifications for each deliverable;
 - 1.4.1.2. Engage the MCOs in the development of measures as appropriate;
 - 1.4.1.3. Schedule "Exhibit O" meetings (webinars, typically held on Friday afternoons) with the MCOs to:
 - 1.4.1.3.1. Review all deliverable specifications;
 - 1.4.1.3.2. Provide clarifications as needed by the MCOs;
 - 1.4.1.3.3. Establish initial due dates for all deliverables.
 - 1.4.1.4. Provide training for use of the NH Medicaid Quality Information System (MQIS) and the DHHS SharePoint site;
 - 1.4.1.5. Contact MCO compliance staff to validate suspected reporting discrepancies.
 - 1.4.2. MCO compliance staff and appropriate subject matter experts (SMEs) shall:
 - 1.4.2.1. Review, sign, and comply with all applicable DHHS and DoIT applicable policies and procedures;
 - 1.4.2.2. Review all specifications for clarity and request more information as needed;
 - 1.4.2.3. Participate in measure development activities as appropriate;
 - 1.4.2.4. Participate in the "Exhibit O" meetings;
 - 1.4.2.5. Follow the finalized specifications for submission of deliverables;
 - 1.4.2.6. Gain access to and utilize the MQIS, including participation in any DHHS required training necessary;
 - 1.4.2.7. Submit all data as required to MQIS using MQIS specified formats;
 - 1.4.2.8. Submit deliverables as required to the DHHS SharePoint site;
 - 1.4.2.9. Respond to system generated error reports;

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EXHIBIT O – Quality and Oversight Reporting Requirements Amendment #10

- 1.4.2.10. Respond to requests from DHHS staff to validate suspected reporting discrepancies.
- 1.5. The Department reserves the right to develop and require alternative methodologies to submit data.
- 2. Key Definitions
 - 2.1. The following terms include some of the unique or new terms found in Exhibit O. Please reference Exhibit A for more details.

Term	Definition
2.1.1. Community Hospital	Any hospital other than New Hampshire Hospital
2.1.2. Community Mental Health Program or CMHP, High Risk / High Need, Local Care Management, and Priority Populations	As defined in Exhibit A.
2.1.3. Subpopulations	<p>Subpopulations consist of components used together to classify a member and are used for selected measures as indicated in the NH Medicaid Care Management Quality and Oversight Reporting Deliverables table below.</p> <p>General subpopulations utilize the following components: Age Group, Member Type, LTSS Type, and Payer Type. Measures use specific components in conjunction based on the measurement intent.</p> <p>Each component is broken down into the following categories that have standardized definitions used consistently across all measures:</p> <ul style="list-style-type: none"> • Age Group (<i>Children, Adults, Older Adults</i>), • Member Type (DCYF Involved Child, Child with Severe Disabilities (HC-CSD, SSI, SMS), Other Special Needs Child, Other Child, Special Needs Adult, All Other Adults, All Older Adults), • LTSS Type (Receiving LTC Services (Waiver or Nursing Home), Eligible for CMHC Services and Not Also Waiver/Nursing Home, Not Receiving Waiver, CMHC, or Nursing Home), and • Payer Type (Medicaid Primary, Medicare Primary, Other Primary)

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
ACCESSREQ.05	Requests for Assistance Accessing MCO Designated Primary Care Providers by County	Count and percent of member telephone and/or email requests for assistance accessing MCO Designated Primary Care Providers (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer appearing on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period							X	
ACCESSREQ.06	Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County	Count and percent of member telephone and/or email requests for assistance accessing non-MCO Designated Physician/APRN Specialists (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period							X	
AMBCARE.10	Physician/APRN/Clinic Visits	Count and percent of Physician/APRN/Clinic visits per 1,000 member months by subpopulation.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
AMBCARE.11	Emergency Department Visits for Physical Health Conditions	Count and percent of Ambulatory emergency department (ED) visits per 1,000 member months by subpopulation. This measure excludes ED visits for mental health and substance use disorder/substance misuse conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.12	Emergency Department Visits - Potentially Treatable in Primary Care	Count and percent of Ambulatory emergency department visits for conditions potentially treatable in primary care per 1,000 member months by subpopulation.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.13	Emergency Department Visits - Mental Health Conditions	Count and percent of Ambulatory emergency department (ED) visits for mental health conditions per 1,000 member months by subpopulation. This measure excludes ED visits for substance use disorder/substance misuse conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X	X	
AMBCARE.14	Emergency Department Visits - Substance Use Disorder and Substance Misuse Related Conditions	Count and percent of Ambulatory emergency department visits for substance use disorder (SUD) and substance misuse related conditions per 1,000 member months by subpopulation. This measure excludes ED visits for mental health conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.18	Frequent Emergency Department Use	Count and percent of members with frequent ED use in the previous 12 months, by subpopulation. Frequent ED use is defined as 4+ visits in a 12-month period. This measure includes ED visits for physical health; mental health and substance use disorder/substance misuse conditions.	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X		
AMBCARE.20	Emergency Department Visits for Any Condition by Subpopulation	Count and percent of all Ambulatory emergency department (ED) visits for Medical Health, Behavioral Health and Substance Use Related (Chronic or Acute) Conditions (Total counts, not broken out by condition group).	Measure	General	Quarter	Quarterly	4 Months after end of Measurement Period					X	X	X	

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
ANNUALRPT.01	Medicaid Care Management Program Comprehensive Annual Report	The annual report is the Managed Care Organization's PowerPoint presentation on the accomplishments and opportunities of the prior agreement year. The report will address how the MCO has impacted Department priority issues, social determinants of health, improvements to population health, and developed innovative programs. The audience will be the NH Governor, legislature, and other stakeholders.	Narrative Report		Agreement Year	Annually	August 30th						X		X
APM.01	Alternative Payment Model Plan	Implementation plan that meets the requirements for Alternative Payment Models outlined in the MCM Model Contract and the Department's Alternative Payment Model Strategy.	Plan		Varies	Annually	May 1st								X
APM.02	Alternative Payment Model Quarterly Update	Standard template showing the quarterly results of the alternative payment models.	Table		Varies	Quarterly	4 Months after end of Measurement Period								X
APM.03	Alternative Payment Model Completed HCP-LAN Assessment Results	The HCP-LAN Assessment is available at: https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf ; the MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).	Narrative Report		Varies	Annually	October 31st								X
APPEALS.01	Resolution of Standard Appeals Within 30 Calendar Days	Count and percent of appeal resolutions of standard appeals within 30 calendar days of receipt of appeal for appeals filed with the MCO during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.02	Resolution of Extended Standard Appeals Within 44 Calendar Days	Count and percent of appeal resolutions of extended standard appeals within 44 calendar days of receipt of appeal for appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
APPEALS.03	Resolution of Expedited Appeals Within 72 Hours	Count and percent of appeal resolutions of expedited appeals within 72 hours of receipt of appeal for appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.04	Resolution of All Appeals Within 45 Calendar Days	Count and percent of appeal resolutions within 45 calendar days of receipt of appeal for appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.05	Resolution of Appeals by Disposition Type	Count and percent of appeals where member abandoned appeal, MCO action was upheld, or MCO action was reversed for all appeals received during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.16	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Standard template that provides counts of MCO resolved appeals by resolution type (i.e. upheld, withdrawn, abandoned) by category of service. The counts are broken out by State Plan and 1915B waiver populations.	Table		Quarter	Quarterly	2 Months after end of Measurement Period				X	X	X		
APPEALS.17	Pharmacy Appeals by Type of Resolution and Therapeutic Drug Class by State Plan, 1915B Waiver, and Total Population	Standard template providing counts of MCO appeals resolutions by resolution type and category of pharmacy class	Table		Quarter	Quarterly	2 Months after end of Measurement Period				X	X	X		
APPEALS.18	Services Authorized within 72 Hours fol03 - Lowing a Reversed Appeal	Count and percent of services authorized within 72 hours fol03 - Lowing a reversed appeal for the service that was previously denied, limited or delayed by the MCO.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X
APPEALS.19	Member Appeals Received	Count and percent of Member appeals filed during the measurement data period, per 1,000 member months.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
BHDRUG.01	Severe Mental Illness Drug Prior Authorization Report	Standard template to monitor MCO pharmacy service authorizations (SA) for drugs to treat severe mental illness that are prescribed to members receiving services from Community Mental Health Programs. The report includes aggregate data detail related to SA processing timeframes, untimely processing rates, peer-to-peer activities, SA approval and denial rates. The report also includes a log of member specific information related to SA denials.	Table		Quarter	Quarterly	1 Month after end of Measurement Period								X
BHPARITY.01	Behavioral Health Parity Attestation	Standard report for MCO to attest to compliance with behavioral health parity requirements.	Table		Calendar Year	Annually	January 31st						X		X
BHSTRATEGY.01	Behavioral Health Strategy Plan and Report	Annual comprehensive plan describing the MCOs policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers.	Plan		Agreement Year	Annually	May 15th							X	X
BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report	Standard template to report the results of the annual behavioral health consumer satisfaction survey for members with mental health and substance use disorder (SUD) conditions. The report includes all mandatory questions for the survey.	Table		Calendar Year	Annually	June 30th	X							

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Description			Measurement Period and Delivery Dates				Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAHPS_A.01	Adult CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the Adult Medicaid CAHPS 5.0 survey population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3; Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X		X			X		
CAHPS_A.02	Adult CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the Adult Medicaid CAHPS 5.0H Validated Member Level Data File.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X		X			X		
CAHPS_A.03	Adult CAHPS: Medicaid Adult Survey Results Report	This report includes summary information about the Adult Medicaid CAHPS 5.0H survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X		X			X		
CAHPS_A.04	Adult CAHPS: CAHPS Survey Results with Confidence Intervals	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X		X			X		
CAHPS_A.05	Adult CAHPS: Survey Instrument Proofs created by Survey Vendor	Adult Medicaid CAHPS 5.0H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	Feb 28th	X		X			X		

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAHPS_A_SUP	Adult CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRO.	Measure		Standard HEDIS Schedule	Annually	July 31st	X					X		X
CAHPS_CCC.01	Child w CCC CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the CAHPS Medicaid Child with CCC 5.0H survey population. This file will include respondents identified as either General Population, or Child with Chronic Conditions (Child with CCC) Population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3, Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
CAHPS_CCC.02	Child w CCC CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the CAHPS Child with CCC 5.0H Survey Validated Member Level Data File.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
CAHPS_CCC.03	Child w CCC CAHPS: Medicaid Child with CCC - CCC Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAHPS_CCC.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - Child with CCC	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X	X				X		
CAHPS_CCC.05	Child w CCC CAHPS: Survey Instrument Proofs created by Survey Vendor	CAHPS Child with CCC 5.0H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	Feb 28th	X	X				X		
CAHPS_CCC_SUP	Child CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure		Standard HEDIS Schedule	Annually	July 31st	X					X		X
CAHPS_CGP.03	Child w CCC CAHPS: Medicaid Child with CCC - General Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
CAHPS_CGP.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - General Population	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X	X				X		

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	3115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CARECOORD.03	Neonatal Abstinence Syndrome Referrals to Care Management	Count and percent of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) during the measurement quarter referred to case management within 30 calendar days of diagnosis.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
CARECOORD.04	Neonatal Abstinence Syndrome Engagement in Care Management	Count and percent of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) during the measurement quarter who enrolled with the MCO care management program within 30 days of the referral.	Measure		Quarter	Quarterly	5 Months after end of Measurement Period								X
CAREMGT.01	Care Management Plan Including Plan to Assess and Report on the Quality and Appropriateness of Care Furnished to Members With Special Health Care Needs	Overview of the MCO plan to implement and operate their comprehensive care management program for the next agreement year.	Plan		Agreement Year	Annually	May 1st								X
CAREMGT.23	Care Management Comprehensive Assessments Completed by Subcontractor Entity	Percent of completed comprehensive assessments in the quarter completed by a subcontractor entity.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.24	Care Management: Comprehensive Assessment Attempts Completed Within 30 Days	Count and percent of members requiring a comprehensive assessment within 30 days of being identified as requiring this assessment, by outcome of MCO completion attempts.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAREMGT.25	Care Management Comprehensive Assessment Results within 14 Calendar Days	Percent of members with a comprehensive assessment completed during the measurement quarter, where the assessment results were shared in writing with members of the local-based care team within 14 calendar days of being established. The local-based care team includes but is not limited to the member's PCP, specialist, behavioral health provider, and local care management entity.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.26	Care Management Resources - Unmet Needs	Standard template aggregating by county, resource needs (e.g. housing supports, providers) that cannot be met because they are not locally available. Data will be based on the care screening and comprehensive assessments conducted during the quarter.	Table		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.28	Care Management: Members Receiving Care Management by Priority Population	Standard template capturing quarterly counts of members enrolled in care management-during the quarter broken out by priority populations outlined in the Care Coordination and Care Management section of the MCM Contract. Enrollment in care management is defined as the member having a completed plan of care.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X
CAREMGT.29	Care Management Outreach to High-Risk/High-Need Members	Count and percent of members who received outreach from the MCO to enroll in care management within 30 calendar days of being identified as High-risk or High-need through a completed comprehensive assessment, by the outcome of MCO outreach.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.32	Members Receiving Face-to-Face Local Care Management	Count and percent of members enrolled in local care management during the measurement quarter, who had at least one face-to-face meeting with their local case manager or designee during the quarter.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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EXHIBIT O – Quality and Oversight Reporting Requirements

Description			Measurement Period and Delivery Dates				Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CAREMGT.39	Members Enrolled in Care Management	Count and percent of members enrolled in care management on the last day of the month. Enrollment in care management is defined as the member having a completed plan of care.	Measure		Month	Monthly	1 Month after end of Measurement Period					X			X
CAREMGT.40	Members Enrolled in Care Management at Any Time During the Month	Count and percent of members enrolled in care management at any time during the month. Enrollment in care management is defined as the member having a completed plan of care.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.41	Members Receiving Local Care Management by Geographic Region	Count and percent of members who are enrolled in care management and receiving local care management at the end of the measurement month, by geographic region.	Measure		Month	Monthly	1 Month after end of Measurement Period								X
CAREMGT.42	Members Identified as High-Risk/High-Need Receiving Care Management	Count and percent of members identified as "High-risk"/"High-need" through the comprehensive assessment completed in the measurement quarter, who enrolled in care management within 30 calendar days of completion of the comprehensive assessment.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
CAREMGT.43	Members Receiving Care Management by Geographic Region	Count and percent of members who are enrolled in care management at the end of the measurement month, by geographic region.	Measure		Month	Monthly	1 Month after end of Measurement Period								X

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CAREMGT.44	Successful Member Welcome Calls	<p>Count and percent of members newly enrolled in an MCO during the measurement period for whom the MCO completed a welcome call within 30 calendar days of enrollment. The welcome call contract requirements are as follows:</p> <ul style="list-style-type: none"> • The MCO shall make a welcome call to each New Member within thirty (30) calendar days of the Member's enrollment in the MCO. • The welcome call shall, at a minimum: <ul style="list-style-type: none"> o Assist the Member in selecting a PCP or confirm selection of a PCP; o Arrange for a wellness visit with the Member's PCP (either previously identified or selected by the Member from a list of available PCPs), which shall include: <ul style="list-style-type: none"> o Assessments of both physical and behavioral health, o Screening for depression, mood, suicidality, and Substance Use Disorder, and o Development of a health, wellness and care plan; o Include a Health Risk Assessment Screening as required in Section 4.10.2.2, or schedule the Health Risk Assessment to be conducted within the time limits identified in this Agreement; o Screen for special needs, physical and behavioral health, and services of the Member; o Answer any other Member questions about the MCO; o Ensure Members can access information in their preferred language; and o Remind Members to report to DHHS any change of address, as Members shall be liable for premium payments paid during period of ineligibility. 	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X
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CAREMGT.45	New Member Welcome Calls – MCO Arranged Wellness Visit	Count and percent of members newly enrolled in an MCO during the measurement period for whom the MCO completed a welcome call within 30 calendar days of enrollment and arranged a wellness visit for the member or other covered family member, broken out by the results of the wellness visit conversation. • MCO Arranged Wellness Visit • Member Declined MCO Assistance to Arrange Wellness Visit • Member Wanted Assistance to Arrange Wellness Visit but MCO was Unable to Arrange Visit • MCO Did Not Offer to Arrange Wellness Visit	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X
CAREMGT.46	New Member Wellness Visits – Visit Occurred	Count and percent of members newly enrolled in an MCO during the measurement period where the member had a wellness visit within 6 months of their enrollment date.	Measure		Quarter	Quarterly	10 Months after end of Measurement Period								X
CLAIM.08	Interest on Late Paid Claims	Total interest paid on professional and facility claims not paid within 30 calendar days of receipt using interest rate published in the Federal Register in January of each year for the Medicare program. Note: Claims include both Medical and Behavioral Health claims.	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period						X		X
CLAIM.11	Professional and Facility Medical Claim Processing Results	Count and percentage of professional and facility medical claims received in the measurement period, with processing status on the last day of the measurement period that are Paid, Suspended, or Denied.	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period						X		X

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CLAIM.17	Average Pharmacy Claim Processing Time	The average pharmacy claim processing time per point of service transaction, in seconds. The contract standard in Amendment 7, section 14.1.9 is: The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds. Note: Claims include both Medical and Behavioral Health claims.	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period						X		X
CLAIM.21	Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt	Count and percent of clean electronic provider claims processed within 15 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period					X	X		X
CLAIM.22	Timely Processing of Non-Electronic Provider Claims: Thirty Days of Receipt	Count and percent of clean non-electronic provider claims processed within 30 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period					X	X		X
CLAIM.23	Timely Processing of All Clean Provider Claims: Thirty Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure		Month	Monthly	50 Calendar Days after end of Measurement Period					X	X		X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CLAIM.24	Timely Processing of All Clean Provider Claims: Ninety Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 90 calendar days of receipt of the claim, for those received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT) claims.	Measure		Month	Monthly	110 Calendar Days after end of Measurement Period						X		X
CLAIM.25	Claims Quality Assurance - Claims Payment Accuracy	Sampled percent of all provider claims that are paid or denied correctly during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure		Quarter	Quarterly	50 Calendar Days after end of Measurement Period					X	X		X
CLAIM.26	Claims Quality Assurance: Claims Financial Accuracy	Sampled percent of dollars accurately paid for provider claims during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims. Note: It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.	Measure		Quarter	Quarterly	50 Calendar Days after end of Measurement Period					X	X		X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CLAIM.27	Claims Quality Assurance: Claims Processing Accuracy	Sampled percent of all provider claims that are accurately processed in their entirety from both a financial and non-financial perspective during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure		Quarter	Quarterly	50 Calendar Days after end of Measurement Period					X	X		X
CMS_A_AMM.01	Antidepressant Medication Management: Effective Acute Phase Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS AMM measure.	Measure		May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	September 30th			X					
CMS_A_AMM.02	Antidepressant Medication Management: Effective Continuation Phase Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS AMM measure.	Measure		May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	September 30th			X					
CMS_A_AMR	Asthma Medication Ratio	CMS Adult Core Set - Age breakout of data collected for HEDIS AMR measure.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_BCS	Breast Cancer Screening	CMS Adult Core Set - Age breakout of data collected for HEDIS BCS measure.	Measure		2 Calendar Years	Annually	September 30th			X					

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CMS_A_CBP	Controlling High Blood Pressure	CMS Adult Core Set - Age breakout of data collected for HEDIS CBP measure.	Measure		Calendar Year	Annually	September 30th		X						
CMS_A_CCP.01	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days	CMS Adult and Child Core Sets - The percentage of women ages 15 through 44 who had a live birth and were provided a most or moderately effective method of contraception within 3 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_CCP.02	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a most or moderately effective method of contraception within 60 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_CCP.03	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 3 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_CCP.04	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 60 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 60 days of delivery by age group.	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_CDF	Screening for Clinical Depression and Follow-up Plan	CMS Adult and Child Core Sets (member age determines in which set the member is reported)	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_A_COL	Colorectal Cancer Screening	CMS Adult Core Set - Age breakout of data collected for HEDIS COL measure.	Measure		Calendar Year with a 10 Year Look-back	Annually	September 30th			X					
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set - Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	Measure		Calendar Year	Annually	September 30th			X	X				

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CMS_A_FUA.01	Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Within 7 Days of ED Visit	CMS Adult Core Set - Age breakout of data collected for HEDIS FUA measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_FUA.02	Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Within 30 Days of ED Visit	CMS Adult Core Set - Age breakout of data collected for HEDIS FUA measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_HBD.01	Hemoglobin A1c Control for Patients With Diabetes - HbA1c control (<8.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c control (<8.0%).	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_HBD.02	Hemoglobin A1c Control for Patients With Diabetes - HbA1c poor control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c poor control (>9.0%).	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for a former HEDIS measure.	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_IET.01	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.02	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CMS_A_IET.03	Initiation of Alcohol Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.04	Engagement of Alcohol Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.05	Initiation of Opioid Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.06	Engagement of Opioid Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.07	Initiation of Other Drug Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_IET.08	Engagement of Other Drug Abuse or Dependence Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_INP_PQI01	Diabetes Short-Term Complication Admissions	CMS Adult Core Set - Diabetes Short-Term Complications Admission Rate per 100,000 Member Months	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_INP_PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions	CMS Adult Core Set - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_INP_PQI08	Heart Failure Admissions	CMS Adult Core Set - Heart Failure Admission Rate per 100,000 Enrollee Months	Measure		Calendar Year	Annually	September 30th			X					

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EXHIBIT D – Quality and Oversight Reporting Requirements

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
CMS_A_INP_PQI15	Asthma in Younger Adults Admissions	CMS Adult Core Set - Asthma in Younger Adults Admission Rate per 100,000 Enrollee Months	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_MSC.01	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_MSC.02	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_MSC.03	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure		Calendar Year	Annually	September 30th			X					
CMS_A_OHD	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage	CMS Adult Core Set - The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.01	Use of Pharmacotherapy for Opioid Use Disorder - Total	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed medication for the disorder.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.02	Use of Pharmacotherapy for Opioid Use Disorder - Buprenorphine	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Buprenorphine.	Measure		Calendar Year	Annually	September 30th			X	X				

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CMS_A_OUD.03	Use of Pharmacotherapy for Opioid Use Disorder - Oral Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Oral Naltrexone.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.04	Use of Pharmacotherapy for Opioid Use Disorder - Long-Acting, Injectable Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Long-Acting, Injectable Naltrexone.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_A_OUD.05	Use of Pharmacotherapy for Opioid Use Disorder - Methadone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Methadone.	Measure		Calendar Year	Annually	September 30th			X	X				
CMS_CCW.01	Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_CCW.02	Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure		Calendar Year	Annually	September 30th		X	X					
CMS_CH_DEV	Developmental Screening in the First Three Years of Life	CMS Child Core Set - Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Measure		Calendar Year	Annually	September 30th		X						

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CULTURALCOMP.01	Cultural Competency Strategic Plan	MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by communication access utilization reports, quality improvement data disaggregated by race, ethnicity and language, and the community assessments and profiles.	Plan		Agreement Year	Annually	May 1st								X
DUR.01	Drug Utilization Review (DUR) Annual Report	This annual report includes Center for Medicaid and Medicaid Services (CMS) required information on the operation of the MCO's Medicaid DUR Program.	Narrative Report		Federal Fiscal Year	Annually	May 15th						X		X
EMERGENCY RESPONSE.01	Emergency Response Plan	Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs, including, but not limited to, specific pandemic and natural disaster preparedness. After the initial submission of the plan the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.	Plan		Agreement Year	Annually	May 1st								X
EPSDT.01	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	Standard template that captures the total paid units of each of the ABA services by member for the purpose of fiscal impact analysis.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X

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EPSDT.20	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	MCO EPSDT plan includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure provider network compliance that all members under age 21 receive all the elements of the preventive health screenings recommended by the AAP's most currently published Bright Futures guidelines for well-child care in accordance with the EPSDT periodicity schedule. Additionally, the MCO EPSDT plan must include written policies and procedures for the provision of a full range of EPSDT diagnostic and treatment services.	Plan		Agreement Year	Annually	May 1st									X
EQRO.01	MCO Follow-up on EQRO Recommendations	This semi-annual report will provide a description of actions taken to address select MCO-specific findings/recommendations identified by NH EQRO quality reports.	Narrative Report		6 Months	Semi-Annually	1 Month after end of Measurement Period									X
FINANCIALSTMT.01	MCO Annual Financial Statements	The MCO shall provide DHHS a complete copy of its audited financial statements and amended statements.	Narrative Report		MCO Financial Period	Annually	August 10th									X
FWA.02	Fraud Waste and Abuse Log: FWA Related to Providers	Standard template log of all Fraud Waste and Abuse related to providers, in process and completed during the month by the MCO or its subcontractors. This log includes but is not limited to case information, current status, and final outcome for each case including overpayment and recovery information.	Table		Month	Monthly	1 Month after end of Measurement Period						X			X
FWA.04	Fraud Waste and Abuse Log: Date of Death Report	Standard template that captures a list of members who expired during the measurement period.	Table		Month	Monthly	1 Month after end of Measurement Period						X			X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
FWA.05	Fraud Waste and Abuse Log: Explanation Of Medical Benefit Report	Standard template that includes a summary explanation of medical benefits sent and received including the MCO's follow-up, action/outcome for all EMB responses that required further action.	Table		Quarter	Quarterly	1 Month after end of Measurement Period						X		X
FWA.06	Fraud Waste and Abuse Log: Waste Recovery Report	Standard template reporting waste identified and recovered by the MCO.	Table		Quarter	Quarterly	1 Month after end of Measurement Period								X
FWA.20	Comprehensive Annual Prevention of Fraud Waste and Abuse Summary Report	The MCO shall provide a summary report on MCO Fraud, Waste and Abuse investigations. This should include a description of the MCO's special investigation's unit. The MCO shall describe cumulative overpayments identified and recovered, investigations initiated, completed, and referred, and an analysis of the effectiveness of activities performed. The MCO's Chief Financial Officer will certify that the information in the report is accurate to the best of his or her information, knowledge, and belief.	Narrative Report		Agreement Year	Annually	September 30th						X		X
GRIEVANCE.02	Grievance Log Including State Plan / 1915B Waiver Flag	Standard template log of all grievances with detail on grievances and any corrective action or response to the grievance for grievances made within the measure data period.	Table		Quarter	Quarterly	15 Calendar Days after end of Measurement Period			X	X	X			
GRIEVANCE.03	Member Grievances Received	Count and Percent of member grievances received during the measure data period, per 1,000 member months.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period						X		
GRIEVANCE.05	Timely Processing of All Grievances	Count and percent of grievances processed within contract timeframes for grievances made during the measurement period.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period	X					X		

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HEDIS.01	HEDIS Roadmap	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
HEDIS.02	HEDIS Data Filled Workbook	Workbook containing the NCQA audited results for all HEDIS measures, with one measure appearing on each tab.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
HEDIS.03	HEDIS Comma Separated Values Workbook	This file includes NCQA audited results for all HEDIS measures, and should include the Eligible Population and/or Denominator, Numerator, Rate, and Weight (for hybrid measures) for each measure.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	June 30th	X	X				X		
HEDIS.04	NCQA HEDIS Compliance Audit™ Final Audit Report	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/CAHPS Files		Standard HEDIS Schedule	Annually	July 31st	X	X				X		
HEDIS.06	HEDIS Member Level Data	This file contains member/event level data for select HEDIS measures. Data will reflect the NCQA audited results for these measures in the corresponding HEDIS Data-Filled Workbook for the same measurement period. The current list of DHHS-selected HEDIS measures appears in <i>Appendix AF - HEDIS Measures Included in HEDIS.06</i> and is subject to change each measurement year.	HEDIS/CAHPS Files		Calendar Year	Annually	June 30th								

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HEDIS_AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	HEDIS Measure, also utilized for CMS Core Sets	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X	X	X					
HEDIS_ADD	Follow-Up Care for Children Prescribed ADHD Medication	HEDIS Measure, also utilized for CMS Core Sets	Measure		One year starting March 1 of year prior to measurement year to February 28 of measurement year.	Annually	June 30th	X	X						X
HEDIS_AIS-E	Adult Immunization Status - Influenza, Td/Tdap, Zoster, Pneumococcal	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_AMB	Outpatient and Emergency Dept. Visits/1000 Member Months	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th		X			X			X

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HEDIS_AMM	Antidepressant Medication Management	HEDIS Measure, also utilized for CMS Core Sets	Measure		May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	June 30th	X		X					X
HEDIS_AMR	Asthma Medication Ratio	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X	X					
HEDIS_APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_AXR	Antibiotic Utilization for Respiratory Conditions (AXR)	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_BCS	Breast Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure		2 Calendar Years	Annually	June 30th	X		X					X
HEDIS_BCS-E	Breast Cancer Screening	HEDIS Measure	Measure		2 Calendar Years	Annually	June 30th	X							X
HEDIS_BPD	Blood Pressure Control (<140/90) (BPD)	HEDIS Measure formerly part of HEDIS_CDC, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th	X							X
HEDIS_CBP	Controlling High Blood Pressure	HEDIS Measure. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th	X		X					X

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HEDIS_CCS	Cervical Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure		3 Calendar Years	Annually	June 30th	X		X					X
HEDIS_CHL	Chlamydia Screening in Women	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X	X					X
HEDIS_CIS	Childhood Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_COL	Colorectal Cancer Screening (COL)	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year with a 10 Year Look-back	Annually	June 30th			X					
HEDIS_COU	Risk of Chronic Opioid Use (COU)	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X			X				X
HEDIS_CRE	Cardiac Rehabilitation	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_CWP	Appropriate Testing for Pharyngitis	HEDIS Measure	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X							
HEDIS_EED	Eye Exam for Patients With Diabetes (EED)	HEDIS Measure formerly part of HEDIS_CDC, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th	X							X
HEDIS_FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure		Calendar Year	Annually	June 30th	X	X	X	X				X

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HEDIS_FUH	Follow-Up After Hospitalization For Mental Illness	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure		January 1 to December 1 of measurement year	Annually	June 30th	X	X	X					X
HEDIS_FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure		January 1 to December 1 of measurement year	Annually	June 30th	X							X
HEDIS_FUM	Follow-Up After Emergency Department Visit for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure		Calendar Year	Annually	June 30th	X	X	X					X
HEDIS_FVA	Flu Vaccinations for Adults Ages 18–64 (FVA)	HEDIS Measure Collected through the CAHPS Health Plan Survey, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					
HEDIS_HBD	Hemoglobin A1c Control for Patients With Diabetes (HBD)	HEDIS Measure formerly part of HEDIS_CDC. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th	X		X					X
HEDIS_HDO	Use of Opioids at High Dosage	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X			X				X
HEDIS_IET	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure		Calendar Year	Annually	June 30th	X		X	X				X
HEDIS_IMA	Immunizations for Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_KED	Kidney Health Evaluation for Patients with Diabetes	HEDIS Measure, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th	X							X
HEDIS_LBP	Use of Imaging Studies for Low Back Pain	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							

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HEDIS_LSC	Lead Screening in Children	HEDIS Measure, also utilized for CMS Core Sets.	Measure		Calendar Year	Annually	June 30th		X						X
HEDIS_MSC	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	HEDIS Measure Collected through the CAHPS Health Plan Survey	Measure		Calendar Year	Annually	June 30th	X		X					
HEDIS_PCE	Pharmacotherapy Management of COPD Exacerbation	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_PCR	Plan All-Cause Readmissions	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					X
HEDIS_POD	Pharmacotherapy for Opioid Use Disorder	HEDIS Measure	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X							X
HEDIS_PPC	Prenatal and Postpartum Care	HEDIS Measure, also utilized for CMS Core Sets. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th	X	X	X					X
HEDIS_PRS-E	Prenatal Immunization Status	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_RDM	Race/Ethnicity Diversity of Membership	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_SAA	Adherence to Antipsychotics for Individuals with Schizophrenia	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					X

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HEDIS_SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS Measure	Measure		Calendar Year	Annually	June 30th								X
HEDIS_SPC	Statin Therapy for Patients with Cardiovascular Disease	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_SPD	Statin Therapy for Patients with Diabetes	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X							
HEDIS_SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X		X					X
HEDIS_UOP	Use of Opioids from Multiple Providers	HEDIS Measure	Measure		Calendar Year	Annually	June 30th	X			X				X
HEDIS_UR1	Appropriate Treatment for Upper Respiratory Infection	HEDIS Measure	Measure		One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th	X							
HEDIS_W30	Well-Child Visits in the first 30 Months of Life	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th		X				X		X

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HEDIS_WCC	Weight Assessment and Counseling	HEDIS Measure, also utilized for CMS Core Sets	Measure		Calendar Year	Annually	June 30th	X	X						X
HEDIS_WCV	Child and Adolescent Well-Care Visits	HEDIS Measure, also utilized for CMS Core Sets Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure		Calendar Year	Annually	June 30th		X				X		X
HRA.08	Successful Completion of MCO Health Risk Assessment	Percent of members for whom the MCO shows completion of a health risk assessment during the measurement year, as of the last day of the measurement year. This measure excludes members newly eligible for Medicaid in the last three months of the measurement year.	Measure		Year	Quarterly	2 Months after end of Measurement Period								
HRA.09	Health Risk Assessment Narrative Report	Narrative description of the MCO's efforts to assure 25% of the members have a completed Health Risk Assessment including reasons for not achieving the contract standard.	Narrative Report		Quarter	Quarterly	2 Months after end of Measurement Period								
IMDDISCHARGE.01	State of NH IMD Hospital Discharges - Member Received Discharge Instruction Sheet	Count and percent of discharges from a State of NH IMD Hospital where the member received a discharge instruction sheet upon discharge.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
IMDDISCHARGE.02	State of NH IMD Hospital Discharges - Discharge Plan Provided to Aftercare Provider Within 7 Calendar Days of Member Discharge	Count and percent of members discharged from a State of NH IMD Hospital where the discharge progress note was provided to the aftercare provider within 7 calendar days of member discharge. The contract standard = at least ninety percent (90%) of members discharged.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X

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IMDDISCHARGE.03	State of NH IMD Hospital Discharges - New CMHC Patient Had Intake Appointment with CMHC within 7 Calendar Days of Discharge	Count and percent of State of NH IMD Hospital discharges where the patient had an intake appointment with a NH Community Mental Health Center (NH CMHC) within 7 calendar days of discharge AND who were new to the NH CMHC system.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
IMDDISCHARGE.04	State of NH IMD Hospital Discharges - MCO Contacts and Contact Attempts	Count and percent of members discharged from a State of NH IMD Hospital during the measurement period, where the MCO either successfully contacted the member, or attempted to contact the member at least 3 times, within 3 business days of discharge.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
IMDDISCHARGE.05	Follow-up Visit after Discharge from a State of NH IMD Hospital - Within 7 Days of Discharge	Count and percent of member discharges from a State of NH IMD Hospital where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge, by age group and CMHC eligibility. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
IMDDISCHARGE.06	Follow-up Visit after Discharge from a State of NH IMD Hospital - Within 30 Days of Discharge	Count and percent of member discharges from a State of NH IMD Hospital where the member had at least one follow-up visit with a mental health practitioner within 30 calendar days of discharge, by age group and CMHC eligibility. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
IMDREADMIT.01	Readmissions to State of NH IMD Hospital - Within 30 Days of Discharge	Count and percent of member readmissions to a State of NH IMD Hospital within 30 days of discharge, by age group and CMHC eligibility.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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IMDREADMIT.02	Readmissions to State of NH IMD Hospital - Within 180 Days of Discharge	Count and percent of member readmissions to a State of NH IMD Hospital within 180 days of discharge, by age group and CMHC eligibility.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
IMDREADMIT.03	ED Visits for Mental Health Preceded by a State of NH IMD Hospital Stay in Past 30 Days	Count and percent of mental health related emergency department visits that were preceded within 30 days by a discharge from a State of NH IMD Hospital and not followed by a readmission to a State of NH IMD Hospital, for continuously enrolled Medicaid members, by age group and CMHC eligibility. The primary diagnosis for the ED visit must be mental health related.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
INLIEUOF.01	In Lieu of Services Report	A narrative report describing the cost effectiveness of each approved In Lieu of Service by evaluating utilization and expenditures.	Narrative Report		Agreement Year	Annually	November 1st						X		X

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INPASC.04	Inpatient Hospital Utilization - Ambulatory Care Sensitive Conditions	Count and percent of Inpatient hospital utilization for ambulatory care sensitive conditions per 1,000 adult member months, by subpopulation. This measure includes the following ambulatory care sensitive conditions, as defined for the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators Overall Composite (PQI #90): Diabetes Short-Term Complications (PQI #11); Diabetes Long-Term Complications (PQI #3); Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (PQI #5); Hypertension (PQI #7); Heart Failure (PQI #8); Dehydration (PQI #10); Bacterial Pneumonia (PQI #11); Urinary Tract Infection (PQI #12); Uncontrolled Diabetes (PQI #14); Asthma in Younger Adults (PQI #15); and Lower-Extremity Amputation among Patients with Diabetes (PQI #16).	Measure	General	Agreement Year	Annually	4 Months after end of Measurement Period					X	X		
INTEGRITY.01	Program Integrity Plan	Plan for program integrity which shall include, at a minimum, the establishment of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse, as required in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438.	Plan		Agreement Year	Annually	May 1st, Upon Revision						X		
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	Standard template listing specific members being locked in to a pharmacy for the measurement period.	Table		Month	Monthly	1 Month after end of Measurement Period								X
LOCKIN.03	Pharmacy Lock-in Activity Summary	Standard template with aggregate data related to pharmacy lock-in enrollment and changes during the measurement period.	Table		Month	Monthly	1 Month after end of Measurement Period								X

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MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	MCO shall annually submit its managed care information system (MCIS) plans to ensure continuous operation of the MCIS. This should include the MCOs risk management plan, systems quality assurance plan, confirmation of 5010 compliance and companion guides, and confirmation of compliance with IRS publication 1075.	Plan		Agreement Year	Annually	June 1st								X
MEMCOMM.01	Member Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound member calls answered by a live voice within 30 seconds, by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period					X	X		X
MEMCOMM.03	Member Communications: Calls Abandoned	Count and percent of inbound member calls abandoned while waiting in call queue, by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period					X	X		X
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	Count and percent of inbound member telephone inquiries connected to a live person by reason for inquiry. Reasons include A: Benefit Question Non-Rx, B: Rx-Question, C: Billing Issue, D: Finding/Changing a PCP, E: Finding a Specialist, F: Complaints About Health Plan, G: Enrollment Status, H: Material Request, I: Information/Demographic Update, J: Giveaways, K: Other, L: NEMT Inquiry	Measure		Month	Monthly	1 Month after end of Measurement Period						X		X
MEMCOMM.24	Member Communications: Calls Returned by the Next Business Day	Count and percent of member voicemail or answering service messages responded to by the next business day.	Measure		Month	Monthly	1 Month after end of Measurement Period						X		X

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MEMINCENTIVE.01	Member Incentive Table	Standard template reporting detail around member incentives including category, number of payments, and dollar value of payments for member incentive payments during the measurement period. Annually the MCO will include a statistically sound analysis of the member incentive program and identify goals and objectives for the following year.	Table		Quarter	Quarterly	2 Months after end of Measurement Period								X
MEMINCENTIVE.02	Member Incentive Plan	Annual member incentive plan including goals and objectives associated with the MCOs member incentive strategy.	Plan		Agreement Year	Annually	May 1st								X
MHACT.01	Adult CMHP Assertive Community Treatment (ACT) Service Utilization	Count and percent of eligible Community Mental Health Program (CMHP) members receiving at least one billed Assertive Community Treatment (ACT) service in each month of the measurement period.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
MHDISCHARGE.01	Follow-up Visit after Community Hospital, APRT Facility or DRF Discharge for Mental Health-Related Conditions - Within 7 Days of Discharge	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF) with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHs Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHs Monitoring
MHDISCHARGE.02	Follow-up Visit after Community Hospital, APRT Facility or DRF Discharge for Mental Health-Related Conditions - Within 30 Days of Discharge	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF) with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 30 calendar days of discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment. Include supplemental data as described in the reporting specification.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHEDBRD.01	Emergency Department Psychiatric Boarding Table	Standard template broken out by children and adults with the number of members who awaited placement in the emergency department or medical ward for 24 hours or more. Summary totals by disposition of those members who were waiting for placement; the average length of stay while awaiting placement; and the count and percent of those awaiting placement who were previously awaited placement within the prior 30, 60 and 90 days.	Table		Month	Monthly	1 Month after end of Measurement Period								X
MHREADMIT.03	Mental Health Readmissions: Service Utilization Prior to Readmission	For Members for the measurement month who represented a readmission within 180 days, the MCO will report on the mental health and related service utilization that directly proceeded readmission in accordance with Exhibit O.	Table		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
MHREADMIT.04	Readmissions for Mental Health Conditions within 30 Days of Discharge - Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF), with a primary diagnosis for a mental health-related condition, readmitted for a mental-health related condition within 30 days of a previous discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHREADMIT.05	Readmissions for Mental Health Conditions within 180 days of Discharge - Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from a community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or a Designated Receiving Facility (DRF), with a primary diagnosis for a mental health-related condition, readmitted for a mental-health related condition within 180 days of a previous discharge, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHREADMIT.06	Readmissions for Mental Health Conditions within 30 Days of Discharge - State of NH IMD Hospitals, Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from either a State of NH IMD Hospital, community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or Designated Receiving Facility (DRF) with a primary diagnosis for a mental health condition, readmitted to any of these facilities for a mental health-related condition within 30 days, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
MHREADMIT.07	Readmissions for Mental Health Conditions within 180 Days of Discharge - State of NH IMD Hospitals, Community Hospitals, APRT Facilities or DRFs	Count and percent of member discharges from either a State of NH IMD Hospital, community hospital, an Acute Psychiatric Residential Treatment (APRT) facility or Designated Receiving Facility (DRF) with a primary diagnosis for a mental health condition, readmitted to any of these facilities for a mental health-related condition within 180 days, by age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period					X			X
MHSUICIDE.01	Zero Suicide Plan	Plan for incorporating the "Zero Suicide" model promoted by the National Action Alliance for Suicide Prevention (US Surgeon General) with providers and beneficiaries.	Plan		Agreement Year	Annually	May 1st								X
MHTOBACCO.01	Adult and Youth CMHP Eligible Members: Smoking Status	Count and percent of Community Mental Health Program (CMHP) Eligible Adult and Youth Members 12-17 and 18 and older who are current tobacco users.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
MLR.01	Medical Loss Ratio Report	Standard template developed by DHHS actuaries that includes all information required by 42 CFR 438.8(k), and as needed other information, including, but not limited to: <ul style="list-style-type: none"> • Total incurred claims; • Expenditures on quality improvement activities; • Expenditures related to activities compliant with the program integrity requirements; • Non-claims costs; • Premium revenue; • Taxes; • Licensing fees; • Regulatory fees; • Methodology for allocation of expenditures; • Any credibility adjustment applied; • The calculated MLR; • Any remittance owed to New Hampshire, if applicable; • A comparison of the information reported with the audited financial report; • A description of the aggregate method used to calculate total incurred claims; and • The number of Member months. [42 CFR 438.8(k)(1)(i)-(xiii); 42 CFR 438.608(a)(1)-(5); 42 CFR 438.608(a)(7)-(8); 42 CFR 438.608(b); 42 CFR 438.8(l)] 	Table		Quarter	Quarterly	9 Months after end of Measurement Period						X		

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	EMHA	DHHS Monitoring
MONTHLYOPS.01	Monthly Operations Report	This report will include details about the employment status of Key Personnel required by the MCO contract.	Table		Month	Monthly	1 Month after end of Measurement Period								X
MSQ.01	Medical Services Inquiry Letter	Standard template log of Inquiry Letters sent related to possible accident and trauma. DHHS will require a list of identified members who had a letter sent during the measurement period with a primary or secondary diagnosis code requiring an MSQ letter. For related ICD Codes please make a reference to Trauma Code Tab in this template.	Table		Month	Monthly	1 Month after end of Measurement Period						X		X
NEMT.15	NEMT Requests Delivered by Type of Medical Service	Count and percent of Non-Emergent Medical Transportation (NEMT) requests delivered, by type of medical service. Types include: A: Hospital, B: Medical Provider, C: Mental Health Provider, D: Dentist, E: Pharmacy, F: Methadone Treatment, G: Other	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
NEMT.18	Results of Scheduled NEMT Trips by Outcome	Percent of Non-Emergent Medical Transportation contracted transportation provider and wheelchair van requests scheduled for all rides requested during the measure data period by outcome of the ride. This measure includes methadone treatment rides. Exclude all Family and Friends Mileage Reimbursement Program legs from this measure. Outcomes include: A: Member cancelled or rescheduled, B: Transportation provider cancelled or rescheduled, C: Member no show, D: Transportation provider no show, E: Other reason trip wasn't made, F: Delivered and G: Unknown if trip occurred.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
NEMT.22	Family and Friends Program NEMT Rides	Count and percent of Non-Emergent Medical Transportation one-way rides delivered through the Family and Friends Mileage program.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
NEMT.24	Scheduled NEMT Trips Delivered On Time	Count and percent of Non-Emergent Medical Transportation (NEMT) contracted transportation provider and wheelchair van requests scheduled and delivered during the measurement period, with an outcome of delivered on time. The following exclusions apply: Exclude Methadone treatment rides. Exclude rides provided by Easter Seals.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
NEMT.25	NEMT Network Adequacy Report	TBD - This will be quarterly by mode of transportation and county. Will work through specifications with MCOs and transportation brokers.	Table		Quarter	Quarterly	TBD								X
NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Annual Filing	Standard template for the MCO to report on the adequacy of its provider network and equal access, including time and distance standards.	Table		Calendar Year	Annually	45 Calendar Days after end of Measurement Period			X	X	X			
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	MCO provider exceptions to network adequacy standards. Exceptions should include necessary detail to justify the exception and a detailed plan to address the exception.	Table		Calendar Year	Annually, Ad hoc as warranted	45 Calendar Days after end of Measurement Period			X	X	X			
NETWORK.11	Access to Care Provider Survey	Results of the MCO annual timely access to care provider survey reported in a standard template.	Table		Agreement Year	Annually	45 Calendar Days after end of Measurement Period			X	X	X			

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
PDN.04	Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for child members (age 0-20 years of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
PDN.05	Private Duty Nursing: Authorized Hours for Adults Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for adult members (age 21 and older of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
PDN.07	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Year to Date detail related to members receiving private duty nursing services.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X
PDN.08	Private Duty Nursing: Network Adequacy Report	Standard template measuring the adequacy of the MCOs network for delivering private duty nursing services	Narrative Report		Quarter	Quarterly	TBD								X
PHARM_PDC.01	Proportion of Days Covered - Diabetes All Class Rate (PDC-DR)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Diabetes All Class.	Measure		Calendar Year	Annually	April 30th								X

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PHARM_PDC.02	Proportion of Days Covered - Renin Angiotensin System Antagonists (PDC-RASA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Renin Angiotensin System Antagonists.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.03	Proportion of Days Covered - Statins (PDC-STA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for statins.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.04	Proportion of Days Covered - Beta-Blockers (PDC-BB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for beta-blockers.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.05	Proportion of Days Covered - Calcium Channel Blockers (PDC-CCB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for calcium channel blockers.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.10	Proportion of Days Covered (PDC) - Adherence to Direct-Acting Oral Anticoagulants (PDC-DOAC)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to direct-acting oral anticoagulants.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.11	Proportion of Days Covered - Adherence to Long-Acting Inhaled Bronchodilator Agents in COPD Patients (PDC-COPD)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to long-acting inhaled bronchodilator agents in COPD patients.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.12	Proportion of Days Covered - Antiretroviral Medications (PDC-ARV)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for antiretroviral medications.	Measure		Calendar Year	Annually	April 30th								X

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Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
PHARM_PDC.13	Proportion of Days Covered - Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis (PDC-MS)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused disease modifying agents used to treat Multiple Sclerosis.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.14	Adherence to Non-Infused Biologic Medications Used to Treat Rheumatoid Arthritis (PDC-RA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused biologic medications used to treat rheumatoid arthritis.	Measure		Calendar Year	Annually	April 30th								X
PHARM_PDC.15	Proportion of Days Covered Composite (PDC-CMP)	The composite percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year for: diabetes medications, RAS antagonists, and statins. This is a composite health plan performance measure that combines rates from the following component measures: • Component 1: Proportion of Days Covered: Diabetes All Class (PDC-DR) • Component 2: Proportion of Days Covered: Renin Angiotensin System Antagonist (PDC-RASA) • Component 3: Proportion of Days Covered: Statins (PDC-STA)	Measure		Calendar Year	Annually	April 30th								X
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Count and percent of opioid prescription fills that were prior authorized to meet the NH DHHS Morphine Equivalent Doses (MED) Prior Authorization policy in effect for the measurement period, including members with cancer or other terminal illnesses.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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PHARMQI.10	Child Psychotropic Medication Monitoring Report	Standard template of patient level and aggregated data related to children 0-18 with multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications. Totals are broken out by age categories and whether the child was involved with the Division for Children, Youth, and Families.	Table		Quarter	Quarterly	1 Month after end of Measurement Period								X
PHARMUTLMGT.02	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Count and percent of prescriptions filled for generic drugs adjusted for preferred PDL brands. (To adjust for PDL, remove brand drugs which are preferred over generics from the multi-source claims; and remove their generic counterparts from generic claims).	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
PHARMUTLMGT.03	Pharmacy Utilization Management: Generic Drug Substitution	Count and percent of prescriptions filled where generics were available, including multi-source claims.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
PHARMUTLMGT.04	Pharmacy Utilization Management: Generic Drug Utilization	Count and percent of prescriptions filled with generic drugs out of all prescriptions filled.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

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PMP.01	Program Management Plan	<p>The Program Management Plan (PMP) is a document used to provide an overview of the managed care organization's (MCO) delivery of the program as it operates in New Hampshire. Details and specifications are listed below as the PMP includes key topics and associated descriptions. After the initial year the MCO should submit a certification of no change or provide a red-lined copy of the updated plan.</p> <p>Table of Contents</p> <p>I. Executive Summary</p> <p>II. Organizational structure: a. Staffing and contingency plans; b. Corporation Relationships and Structure</p> <p>III. Business Operations: a. Overview; b. Hours of operation; c. Holidays and emergency closing notification</p> <p>IV. Committees and workgroups: a. General; b. Member Advisory Board; c. Provider Advisory Board</p> <p>V. Communication: a. General; b. Vendor relationships; c. Member management; d. Providers</p> <p>VI. Systems: a. Software and information management; b. Process improvement methods; c. Project management; d. Evaluation methods</p> <p>VII. Providers: a. Management and communication; b. Relationships</p> <p>VIII. Services: a. Pharmacy; b. Behavioral Health; c. Substance Use Disorder; d. Durable medical equipment; e. Special populations; f. Transportation; g. Other Benefits</p> <p>IX. Program Operations: a. Utilization management; b. Grievance and Appeals; c. Care Management</p> <p>X. Community Engagement</p>	Plan	Agreement Year	Annually	May 1st									X
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POLYPHARM.04	Polypharmacy Monitoring: Children with 4 or More Prescriptions for 60 Consecutive Days	Count and percent of child Medicaid members with four (4) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter, by age group: A. Age 0-5 years, B. Age 6-17 years. A PDC of 80 percent or Higher indicates compliance with treatment.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
POLYPHARM.06	Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	Count and percent of adult Medicaid members with five (5) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter by age group: A. Age 18-44, B. Age 45-64 years. A PDC of 80 percent or Higher indicates compliance with treatment.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
PROVAPPEAL.01	Resolution of Provider Appeals Within 30 Calendar Days	Count and percent of provider appeals resolved within 30 calendar days of the Final Provider Appeal Filing Date, for Final Provider Appeals received during the measure data period.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period						X		
PROVAPPEAL.02	Provider Appeals Log	Standard template log of appeals with detail on all provider appeals including the MCO response to the appeal for provider appeals filed within the measure data period.	Table		Quarter	Quarterly	2 Months after end of Measurement Period						X		
PROVCOMM.01	Provider Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound provider calls answered by a live voice within 30 seconds by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period								X

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PROVCOMM.03	Provider Communications: Calls Abandoned	Count and percent of inbound provider calls abandoned either while waiting in call queue by health plan vendor.	Measure		Month	Monthly	1 Month after end of Measurement Period								X
PROVCOMM.07	Provider Communications: Reasons for Telephone Inquiries	Count and percent of inbound provider telephone inquiries connected to a live person by reason for Inquiry. Reasons include A: Verifying Member Eligibility, B: Billing / Payment, C: Service Authorization, D: Change of Address, Name, Contact info, etc. E: Enrollment / Credentialing, F: Complaints About Health Plan, G: Other.	Measure		Month	Monthly	1 Month after end of Measurement Period								X
PROVCOMM.08	Provider Communications: Calls Returned by Next Business Day	Count and percent of provider voicemail or answering service messages returned by the next business day.	Measure		Month	Monthly	1 Month after end of Measurement Period								X
PROVCOMPLAINT.01	Provider Complaint and Appeals Log	Standard template providing a quarterly report of all provider complaints and appeals in process during the quarter.	Table		Quarter	Quarterly	2 Months after end of Measurement Period						X		
PROVPREVENT.01	Hospital-Acquired and Provider-Preventable Condition Table	Standard template that identifies denials or reduced payment amounts for hospital-acquired conditions and provider preventable conditions. Table will include MCO claim identifier, provider, date of service, amount of denied payment or payment reduction and reason for payment denial or reduction.	Table		Annual	Annually	April 30th						X		

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PROVPRIV.01	Behavioral Health Written Consent Report	Narrative reporting of the results of the MCO review of a sample of case files where written consent was required by the member to share information between the behavioral health provider and the primary care provider. In these sample cases, the MCO will determine if a release of information was included in the file. The MCO shall report instances in which consent was not given, and, if possible, the reason why.	Narrative Report		Agreement Year	Annually	4 Months after end of Measurement Period						X		X
PROVTERM.01	Provider Termination Log - including Program Integrity Elements	Standard template log of providers who have given notice, been issued notice, or have left the MCOs network during the measurement period, including the reason for termination. Number of members impacted, impact to network adequacy, and transition plan if necessary.	Table		Month	Monthly	TBD						X		X
QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Plan	Annual description of the MCO's organization-wide QAPI program structure. The plan will include the MCO's annual goals and objectives for all quality activities. The plan will include a description of the mechanisms to detect under and over utilization, assess the quality and appropriateness of care for Member with special health care needs and disparities in the quality of and access to health care (e.g. age, race, ethnicity, sex, primary language, and disability); and process for monitoring, evaluating and improving the quality of care for members receiving behavioral health services.	Plan		Calendar Year	Annually	November 30th						X		

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Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
QAPI.02	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	The report will describe completed and ongoing quality management activities, performance trends for QAPI measures identified in the QAPI plan; and an evaluation of the overall effectiveness of the MCO's quality management program including an analysis of barriers and recommendations for improvement.	Narrative Report		Calendar Year	Annually	February 28th						X		
SDH.XX	Social Determinants of Health	Placeholder for additional measures to show MCO impact on social determinants of health (SDH)	Measure		TBD	TBD	TBD								X
SERVICEAUTH.01	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Count and percent of medical service, equipment, and supply service authorization determinations for urgent requests made within 72 hours after receipt of request for requests made during the measure data period.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.03	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	Count and percent of medical service, equipment, and supply service, authorization determinations for new routine requests made within 14 calendar days after receipt of request for requests made during the measure data period. Exclude authorization requests that extend beyond the 14 day period due to the following: The member requests an extension, or The MCO justifies a need for additional information and the extension is in the member's interest. Exclude requests for non-emergency transportation from this measure.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI/IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SERVICEAUTH.04	Pharmacy Service Authorization Timely Determination Rate	Count and percent of pharmacy service authorization determinations made during the measurement period where the MCO notified the provider via telephone or other telecommunication device within 24 hours of receipt of the service authorization request.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Standard template summary of service authorization determinations by type and benefit decision for request received during the measure data period.	Table		Quarter	Quarterly	2 Months after end of Measurement Period				X				
SERVICEAUTH.13	Medical Service, Equipment and Supply Post-Delivery Service Authorization Timely Determination Rate	Count and percent of post-delivery authorization determinations made within 30 calendar days of receipt of routine requests, for medical services, equipment, and supply services. Exclude requests for non-emergency transportation from this measure.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.14	Service Authorization Denials for Waiver & Non-HCBC Waiver Populations	Rate of service authorizations denied during the measurement period, broken out by the fol03 - Lowing waiver groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X
SERVICEAUTH.15	Service Authorizations: Physical, Occupational & Speech Therapy Service Authorization Denials by Waiver & Non-HCBC Waiver Populations	Rate of physical, occupational and speech therapy service authorizations denied during the measurement period, broken out by the fol03 - Lowing groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Measure		Quarter	Quarterly	2 Months after end of Measurement Period								X

Medicaid Care Management Services Contract – Amendment 10
 New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description			Measurement Period and Delivery Dates				Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SMI_CMS.26	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SMI by Subpopulation	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period. (CMS 1115 SMI DEMONSTRATION Metric #26)	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				
SMI_CMS.30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who are age 18 years and older, and completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication. (CMS 1115 SMI DEMONSTRATION Metric #30)	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				
SUBROGATION.01	Subrogation Report	Standard template identifying information regarding cases in which DHHS has a Subrogation lien. DHHS will inform the MCO of claims related to MCO subrogation cases that need to be included in the report.	Table		Month	Monthly	15 Calendar Days after end of Measurement Period						X		X
SUD.27	Member Access to Clinically Appropriate Services as Identified by ASAM Level of Care Determination Table	Standard template reporting members receiving ASAM SUD services as identified by initial or subsequent ASAM level of care criteria determination within 30 days of the screening. The table will include a file review of a sample of members who received an ASAM SUD service during the measurement period. Age breakouts are 0-17, 18+; exclude duals.	Table		Calendar Year	Annually	6 Months after end of Measurement Period				X				X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD.39	High Opioid Prescribing Provider Monitoring Report	Narrative reporting of the MCO's identification of providers with High opioid prescribing rates and efforts to follow up with providers. The report should include the MCO's operational definition of a provider with a High opioid prescribing rate, the process for identifying and following up with providers. The report should include aggregate data about the number of providers that are identified and the follow up. Age breakouts are 0-17, 18+; exclude duals.	Narrative Report		Agreement Year	Annually	2 Months after end of Measurement Period								X
SUD.42	MCO Contacts and Contact Attempts Following ED Discharges for SUD	Count and percent of member Emergency Department discharges with an SUD principal diagnosis during the measurement period, where the MCO either successfully contacted the member within 3 business days of discharge, or attempted to contact the member at least 3 times within 3 business days of discharge, by age, 0 to 17 years and 18 years or older.	Measure		Quarter	Quarterly	4 Months after end of Measurement Period								X
SUD.52	Member Access to SUD Services following SUD Assessment and Diagnosis	Percent of all Medicaid members with one or more SUD Treatment Services during the measurement period and a 60-day Negative Diagnosis History prior to the first treatment session who had a SUD Assessment within 3 days of the Initial SUD Treatment Service or a SUD Assessment over the course of 3 SUD treatment service sessions delivered within 30 days of the Initial Treatment Service. This assessment can be with the same provider or a different provider.	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCD Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUD_CMS.05	SUD Diagnosis Treated in an IMD by Subpopulation	Count and percent of Medicaid members with a claim for residential treatment for substance use disorder (SUD) in an institution for mental disease (IMD) during the reporting year, by SUD IMD subpopulation. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #5)	Measure		Agreement Year	Annually	4 Months after end of Measurement Period				X				X
SUD_CMS.25	Readmissions among Members with SUD by Subpopulation	The count and percent of acute inpatient stays among Medicaid members with substance use disorder (SUD), during the measurement period, followed by an acute readmission within 30 days, by SUD IMD subpopulation.	Measure		Agreement Year	Annually	4 Months after end of Measurement Period				X				X
SUD_CMS.32_CY	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SUD by Subpopulation	Count and percent of Medicaid members with substance use disorder (SUD) who had an ambulatory or preventive care visit during the measurement period by SUD IMD Waiver subpopulation. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #32)	Measure		Calendar Year	Annually	6 Months after end of Measurement Period				X				X
SUD_CMS.36	Average Length Of Stay In An IMD For SUD by Subpopulation	Average length of stay (in days) in an Institute for Mental Disease (IMD) during the measurement year for Medicaid members who had substance use disorder (SUD) treatment, by SUD IMD subpopulation.	Measure		Agreement Year	Annually	4 Months after end of Measurement Period				X				X
SUDAUDIT.01	SUD Record Audits	All completed audit tools for each of the successive periods under review (PUR).	Table		6 Months	Semi-Annually	January 15th and July 15th								X
SUDAUDIT.02	SUD Record Audit Provider Level Summaries	Standard template that captures a summary of provider level findings from average aggregated scores	Table		6 Months	Semi-Annually	January 31st and July 31st								X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description					Measurement Period and Delivery Dates			Purpose of Monitoring							
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NICQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
SUDAUDIT.03	SUD Record Audits – Opioid Treatment Providers	Case level data from the MCOs audit of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).	Table		TBD	TBD	TBD								X
SUDAUDIT.04	SUD Record Audit Opioid Treatment Providers Provider Level Summaries	Standard template that captures a summary of provider level findings from average aggregated scores for the MCOs audit of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).	Table		TBD	TBD	TBD								X
TIMELYCRED.01	Timely Provider Credentialing - PCPs	The percent of clean and complete provider (PCP) applications for which the MCO or subcontractor credentials the PCP and the provider is sent notice of enrollment within 30 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	NCQA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
TIMELYCRED.02	Timely Provider Credentialing - Specialty Providers	The percent of clean and complete specialty provider applications for which the MCO or credentials the specialty provider and the provider is sent notice of enrollment within 45 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure. Specialty providers include Durable Medical Equipment (DME) and Optometry providers.	Measure		Quarter	Quarterly	3 Months after end of Measurement Period								X
TOBACCO.01	Annual Report of MCO Tobacco Cessation Program Offerings, Operations, and Utilization	The report captures information about MCO Tobacco Cessation offerings, operations and utilization on an annual basis. For each annual submission, submit an updated clean report and a redline version of the updated report.	Narrative Report		Agreement Year	Annually	4 Months After the End of the Measurement Period								X
TOBACCO.04	Tobacco Cessation Activity Report	Report reflecting the volume of members utilizing different tobacco cessation supports such as counseling, medication, and messaging.	Table		Quarter	Quarterly	4 Months after end of Measurement Period								X
TOBACCO.XX	Tobacco Use and Cessation	Placeholder for additional measures to show MCO impact on tobacco use and cessation.	Measure		TBD	TBD	TBD								X
TPLCOB.01	Coordination of Benefits: Costs Avoided Summary Report	Standard template reporting total charge and potential paid amount for claims denied due to other benefit coverage by insurance type for the measure data period.	Table		Quarter	Quarterly	45 Calendar Days after end of Measurement Period								X
TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	Standard template log of COB medical benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans, and workers compensation.	Table		Quarter	Quarterly	45 Calendar Days after end of Measurement Period								X

Medicaid Care Management Services Contract – Amendment 10

New Hampshire Department of Health and Human Services
 Medicaid Care Management Services



EXHIBIT O – Quality and Oversight Reporting Requirements

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Requires DHHS Subpop Breakout	Measurement Period	MCD Submission Frequency	Standard Delivery Date for Measure or Report	NCOA Accreditation	CMS Child Core Set	CMS Adult Core Set	1115 SUD/SMI IMD Waiver	1915b Waiver	Federal Mandate	CMHA	DHHS Monitoring
TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Standard template log of COB pharmacy benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans.	Table		Quarter	Quarterly	45 Calendar Days after end of Measurement Period								X
UMSUMMARY.03	Medical Management Committee	MCO shall provide copies of the minutes from each of the MCO Medical Utilization Management committee (or the MCO's otherwise named committee responsible for medical utilization management) meetings.	Narrative Report		Agreement Year	Annually	2 Months after end of Measurement Period						X		X

State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that BOSTON MEDICAL CENTER HEALTH PLAN, INC. is a Massachusetts Nonprofit Corporation registered to transact business in New Hampshire on December 08, 2011. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: 662906

Certificate Number: 0006235777



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 23rd day of May A.D. 2023.

A handwritten signature in black ink, appearing to read "David M. Scanlan".

David M. Scanlan
Secretary of State

BOSTON MEDICAL CENTER HEALTH PLAN, INC.

Clerk's Certificate

I, Serina Barkley, the duly elected and qualified Clerk of Boston Medical Center Health Plan, Inc. (BMCHP), a Massachusetts non-profit corporation organized under Chapter 180 of the General Laws of Massachusetts, do hereby certify that the Board of Trustees of the Corporation approved the following vote on February 13, 2019:

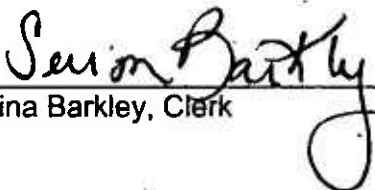
VOTED: To enter into a Medicaid care management contract with the New Hampshire Department of Health and Human Services with coverage effective July 1, 2019.

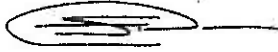
I further certify that the BMCHP Board of Trustees approved the following vote on April 11, 2023:

VOTED: To authorize and direct Heather Thiltgen, as President, James Collins, as Treasurer and Chief Financial Officer, and Serina Barkley, as Clerk, of Boston Medical Center Health Plan, Inc. ("the Corporation"), and Alastair Bell, M.D., as President, Terri Newsom, as Treasurer, and David Beck, as Clerk, of BMC Health System, Inc., acting singly or jointly, to execute, deliver, and file such agreements, documents, instruments and other papers and to take such actions, from time to time in the name of and on behalf of the Corporation, as each of them may deem necessary or appropriate, and that their authority to execute and deliver any such agreements, documents, instruments or other papers and to take any such further actions shall be conclusively evidenced by the execution and delivery thereof or the taking thereof.

I also certify that these votes have not been amended or revoked, and remain in full force and effect as of the 23rd day of May, 2023. This authority remains valid for thirty (30) days from the date of this Clerk's Certificate.

IN WITNESS WHEREOF, I have hereunto set my hand on this 23rd day of May, 2023.


Serina Barkley, Clerk

CERTIFICATE OF INSURANCE					DATE: 5/5/2022		
Strategic Risk Solutions (Cayman) Ltd. Caribbean Plaza, North Building, 2 nd Floor 878 West Bay Road P.O. Box 1159 Grand Cayman, KY1-1102, Cayman Islands alex.hurst@strategicrisks.com			This certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded by the policies below.				
INSURED Boston Medical Center Health Plan Schrafft's City Center 529 Main Street Suite 500 Charlestown, MA 02129			COMPANY AFFORDING COVERAGE				
			A BOSTON MEDICAL CENTER INSURANCE COMPANY, LTD.				
COVERAGES							
This is to certify that the Policies listed below have been issued to the Named Insured above for the Policy Period indicated, notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued or may pertain, the insurance afforded by the policies described herein is subject to all the terms, exclusions and conditions of such policies. Limits shown may have been reduced by paid claims.							
TYPE OF INSURANCE	CO. LTR.	POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS		
GENERAL LIABILITY	A	BMCIC-PR-A-22	06/30/2022	06/30/2023	EACH OCCURENCE	\$2,000,000	
					AGGREGATE	\$2,000,000	
					PERSONAL & ADV INJURY	\$	
					EACH OCCURRENCE	\$	
					FIRE DAMAGE	\$	
COMMERCIAL GENERAL LIABILITY						MEDICAL EXPENSES	\$
CLAIMS MADE							
OCCURRENCE							
PROFESSIONAL LIABILITY					EACH OCCURENCE		
					AGGREGATE		
EXCESS/UMBRELLA LIABILITY					EACH OCCURENCE		
					AGGREGATE		
DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS) Evidencing coverage is in effect							
CERTIFICATE HOLDER			CANCELLATION				
State of New Hampshire, Department of Health and Human Services, Bureau of Contracts and Procurement 129 Pleasant St Concord NH 03301			Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail written notice to the certificate holder named below, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives. Boston Medical Center Insurance Company, LTD shall provide to the Certificate Holder identified herein, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.				
			AUTHORIZED REPRESENTATIVES				
							



CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
11/30/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services Northeast, Inc. Boston MA Office 53 State Street Suite 2201 Boston MA 02109 USA	CONTACT NAME: PHONE (A/C. No. Ext): (866) 283-7122 FAX (A/C. No.): (800) 363-0105	
	E-MAIL ADDRESS:	
INSURED Boston Medical Center Health Plan, Inc. Schrafft's City Center 529 Main Street Boston MA 02129 USA	INSURER(S) AFFORDING COVERAGE	
	INSURER A: Twin City Fire Insurance Company	NAIC # 29459
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	

Holder Identifier :

COVERAGES **CERTIFICATE NUMBER:** 570093089321 **REVISION NUMBER:**

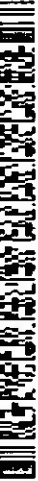
THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. Limits shown are as requested

INSR ITR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION						EACH OCCURRENCE AGGREGATE
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	N/A	39WECEM0708	09/15/2022	09/15/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH E.L. EACH ACCIDENT \$500,000 E.L. DISEASE-EA EMPLOYEE \$500,000 E.L. DISEASE-POLICY LIMIT \$500,000

Certificate No : 570093089321

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
 Evidence of coverage.

CERTIFICATE HOLDER State of New Hampshire Department of Health and Human Services, Bureau of Contracts and Procurement 129 Pleasant Street Concord NH 03301 USA	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE <i>Aon Risk Services Northeast Inc</i>
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**THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT**

License No: 89278605

Presents that **Boston Medical Center Health Plan, Inc. dba Well Sense Health Plan and dba Wellsense**
is hereby authorized to transact **HMO** lines of Insurance
in accordance with State Statute RSA 420-B
Exclusions: 7. HMO Only

Effective Date: 06/15/2023

Expiration Date: 06/14/2024



Christopher R. Nicolopoulos

**Christopher R. Nicolopoulos, Esq.
Commissioner of Insurance**

DEC 15 '22 PM 12:00 RCVD

ARC

13A



Lori A. Shibanette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

December 12, 2022

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into Retroactive amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$245,113,188 from \$4,473,715,686 to \$4,718,828,874 (for the period since contract inception September 2019), with no change to the completion date of August 31, 2024, and effective retroactive to July 1, 2022; upon Governor and Council approval. All terms and conditions of the contract and prior amendment not inconsistent with this Amendment remain in full force and effect. The federal fund share comprises 81% of the price limitation increase, the other non-federal fund share is 12%, and the general fund is 7% from the previous Amendment.

Funding sources are as follows:

	Federal	Other / Agency Income	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	69.34%	1.07%	29.59%
Standard Medicaid Population (Medicaid Care Management)	53.6%	22.4%	24.00%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of FMAP for the Children's Health Insurance Program (CHIP) population remains available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020 (Item #8), January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), as

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 2 of 6

amended on December 08, 2021 (Item #6-1), and as amended on June 15, 2022 (Item # Tabled Item 20A).

Funds are available in the accounts outlined in the attached fiscal details and are available in the State Fiscal Year (SFY) 2023, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

The Centers for Medicare & Medicaid Services (CMS) requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2023.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request is Retroactive because it covers the rating period of July 1, 2022 through June 30, 2023. The methodology used to develop the previous Amendment #8 SFY 2023 capitation rates is largely consistent with the capitation rate methodology in this Amendment #9.

The federal Public Health Emergency (PHE) continues to have an impact on program costs. In order for states to receive the 6.2% enhanced Federal Medical Assistance Percentage (FMAP) the Families First Coronavirus Response Act requires continuous enrollment by states for individuals who were or became Medicaid eligible since March 13, 2020 through at least April 2023. The PHE end date was not noticed on November 12, 2022, so an end of the PHE in January is off the table unless there is Congressional intervention. The PHE, therefore, is likely to run through April 2023.

As of the beginning of December, the NH Medicaid program has 100,481 individuals protected from disenrollment due to continuous enrollment, out of an enrollment of over 246,616 as of December 5, 2022. Absent the continuous enrollment requirement, as of November 30, 2022, more than 29,000 people are known to be ineligible based on completed redeterminations of eligibility (or nearly 12% of current enrollees). Another nearly 35,000 individuals are potentially ineligible since they have not yet completed an annual redetermination of eligibility, which is not required during the PHE. Over 36,000 are both overdue in completing a redetermination and potentially ineligible based on yet to be verified information available to DHHS. Any material disenrollment is unlikely in this rate year, and is likely to begin no earlier than May 1, 2023.

While the State continues to receive 6.2% enhanced FMAP on certain Medicaid expenditures, the enhanced federal payment excludes the NH Granite Advantage Health Care Program at 90% FMAP already, and where enrollment growth for NH has been the greatest both on a percentage (81.6%), and an absolute enrollment growth basis (41,924) since mid-March 2020.

For Amendment #9 relative to the rates:

1. An end of year retroactive non-budget neutral rate adjustment based on actual enrollment was not actuarially made by the State's actuary, as the acuity impact is very likely de minimis.

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2. Rates are calibrated to reflect a PHE end date in April 2023. Once ended, beneficiaries whose eligibility determination shows they no longer meet eligibility criteria will be disenrolled from Medicaid as Federal guidance permits. In order to minimize gaps in healthcare coverage, DHHS, the MCOs, providers and other stakeholders are working to engage beneficiaries. The disenrollment activity is expected to reduce program membership and related costs over the course of the unwind enrollment period.
3. The rates per person aggregate modestly decrease, while the price limitation has increased to reflect the much higher than anticipated enrollment related to the PHE continuing. Generally, states anticipate that when the PHE disenrollment commences, the premiums will rise per person, but the number of people enrolled will decline. Over time, this will lead to lower contract price limitations due to declining enrollment. The enrollment decline and related cost-savings will be realized from exiting individuals who generally have lower illness burden and lower healthcare costs.
4. Tables 1A and 1B in the Appendix depict monthly capitation rates, by major population eligibility groups; and the percent change from the prior Amendment. The rates in Table 1A exclude directed payments which are fixed costs, while Table 1B includes the fixed costs. The price limitation change is calculated off of the Table 1B capitation rates. The rates in the aggregate decline favorably by 0.7% for standard and 2.4% for the GAHCP. Taken together, standard and GAHCP capitation rates decline favorably by 1.5%.
5. Table 2 lays out the capitation rate change components. The top half of the chart shows program changes that increased costs unfavorably by \$7.15 million. The two largest changes are related to legislation enacted into law in the recent legislative session to improve birthing services and ambulance rates. The third largest captures professional billing for Medicaid at state-owned psychiatric facilities. The bottom half of the chart reflects the actuarial rating adjustments that lowered costs by \$27.56 million. The three largest changes are an acuity adjustment, fixed costs that do not increase with the increase in enrollment, and staffed bed constraints in psychiatric capacity.

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shabinette
Commissioner

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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APPENDIX

Table 1A
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Excluding Directed Payments
April PHE End Date

Population	Amendment #8	Amendment #9	Rate Change
Standard Medicaid			
Base Population	\$349.04	\$348.81	-0.1%
CHIP	211.15	213.50	1.1%
Behavioral Health Population	1,459.07	1,431.84	-1.9%
Total Standard Medicaid	\$406.64	\$404.69	-0.4%
Granite Advantage Health Care Program			
Medically Frail	\$1,087.65	\$1,074.95	-2.1%
Non-Medically Frail	419.51	414.34	-1.2%
Behavioral Health Population	2,054.51	2,015.13	-1.9%
Total GAHCP	\$3,561.67	\$3,504.42	-1.6%
Grand Total	\$4,068.31	\$4,009.11	-0.9%

Table 1B
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Including Directed Payments
April PHE End Date

Population	Amendment #8	Amendment #9	Rate Change
Standard Medicaid			
Base Population	\$381.13	\$380.19	-0.3%
CHIP	216.61	218.32	0.8%
Behavioral Health Population	1,514.99	1,483.27	-2.1%
Total Standard Medicaid	\$420.82	\$418.10	-0.6%
Granite Advantage Health Care Program			
Medically Frail	\$1,150.99	\$1,113.50	-3.3%
Non-Medically Frail	432.57	423.65	-2.1%
Behavioral Health Population	2,097.00	2,050.34	-2.2%
Total GAHCP	\$3,680.56	\$3,587.49	-2.3%
Grand Total	\$4,101.38	\$4,005.59	-1.4%

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Rate Component	Standard Medical		GARP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Covered Services and Fee Schedule Changes						
Remote patient monitoring services ¹	0.0%	44,502	0.0%	74,051	0.0%	68,653
Behavioral services reimbursement ²	0.4%	2,704,913	0.0%	258,687	0.2%	2,971,450
Advanced lab tests ³	0.0%	181,054	0.0%	74,476	0.0%	255,630
Ambulance emergency medical transportation rates ⁴	0.1%	1,028,020	0.1%	973,491	0.1%	2,001,611
Friends and family NEMAR rates ⁴	0.0%	305,170	0.1%	483,202	0.1%	758,372
Charter car transportation rates ⁴	0.0%	178,958	0.0%	111,769	0.0%	290,717
State-named hospital professional services ⁴	0.1%	624,648	0.0%	182,776	0.1%	807,424
SUD residential services ⁴	0.0%	724,25	0.1%	546,173	0.0%	618,600
Total program changes	0.7%	5,158,652	0.4%	2,632,525	0.6%	7,772,217
Other changes relative to Amendment #8 SFY 2023 rating assumptions						
SFY 2023 acuity adjustment compared to Amendment #8 acuity assumption ²	-0.2%	(\$1,270,728)	-1.3%	(\$8,519,200)	-0.7%	(\$9,789,928)
October 2022 DRG weights ³	0.0%	158,231	0.0%	193,003	0.0%	351,234
State-named hospital starting constraints ³	-0.4%	(\$2,272,851)	-0.2%	(\$1,087,774)	-0.3%	(\$4,350,625)
Applied behavioral analysis service trends ³	-0.1%	(\$12,628)	0.0%	3,762	-0.1%	(\$98,866)
Impact of enrollment increase on the PMPM value of fixed-dollar directed payments ³	-0.5%	(\$973,112)	-1.1%	(\$7,346,323)	-0.6%	(\$11,319,435)
Other ⁴	-0.1%	(\$15,576)	-0.1%	(\$57,612)	-0.1%	(\$173,188)
Total other changes	-1.3%	(\$9,985,664)	-2.7%	(\$17,514,143)	-2.0%	(\$27,600,587)
Total rate change for Amendment #9 relative to Amendment #8 rates	-0.6%	(\$4,846,972)	-2.3%	(\$14,981,619)	-1.4%	(\$19,828,591)

1 The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.

2 The other change component can include items, such as changes in fee-for-service fees from SFY 2022 to SFY 2023; base data updates, refreshed financial items from MCOs, and modifications to program change effective dates among other things.

3 This change is retroactive to July 1, 2022. The fiscal impact represents a twelve-month period.

4 This change is effective after July 1, 2022. The fiscal impact represents less than a twelve-month period.

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and the Honorable Council
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**Medicaid Care Management Services Contract
Amendment #9 Fiscal Details**

05-95-47-470010-2368 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,148
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,408		\$533,510,408
SFY 2022	101-500729	Medical Payments to Providers	\$575,768,481		\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	\$446,902,230	\$177,489,903	\$624,392,133
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,864,849,263	\$177,489,903	\$2,042,339,166

05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION MEDICAID SERVICES, OFC OF MEDICAID SERVICES CHILD HEALTH INSURANCE PROGRAM

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$102,351,504		\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	\$102,152,951	\$16,223,840	\$118,376,791
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$323,378,814	\$16,223,840	\$339,602,654

05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,278		\$452,028,278
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$618,433,737		\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	\$578,866,727	\$51,399,445	\$630,266,172
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$2,285,487,609	\$51,399,445	\$2,336,887,054
		<i>Total Funds</i>	\$4,473,716,686	\$245,113,188	\$4,718,828,874

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

Lori A. Shibillette
Commissioner

Henry D. Lipman
Director

129 PLEASANT STREET, CONCORD, NH 03301
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May 23, 2022

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$1,127,921,908 from \$3,345,793,778 to \$4,473,715,686, with no change to the completion date of August 31, 2024, and effective July 1, 2022, upon Governor and Council approval. All terms and conditions of the contract and prior amendment not inconsistent with this Amendment remain in full force and effect.

Funding sources are as follows:

	Federal	Other / Agency Income	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	66.1%	1.6%	32.3%
Standard Medicaid Population (Medicaid Care Management)	52.7%	22.2%	25.1%
NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of FMAP for the Children's Health Insurance Program (CHIP) population remains available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements.			

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020

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(Item #6), January 22, 2021 (Item #9), as amended on June 30, 2021 (Item # Tabled Item 8A), and as amended on December 08, 2021 (Item #6-1).

Funds are available in the accounts outlined in the attached fiscal details and are anticipated to be available in the State Fiscal Year (SFY) 2023, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

CMS requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2023.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request covers the rating period of July 1, 2022, through June 30, 2023. There are three key purposes for this amendment. They are:

1. Amendment #8 Target Medical Loss Ratio, Administrative Allowance, and Rates

- The Department's actuary projects an overall MCO medical loss ratio (MLR) for at-risk services of 90.8% for the Standard Medicaid population and 90.1% for the GAHCP population in SFY 2023, which includes the rate development highlights below.
 - An overall 7.7% administrative cost allowance for the Standard Medicaid population, and 8.4% for the GAHCP population; representing a reduction in percentages from SFY 2022 as funding remains consistent with the current contract period.
 - A 1.5% risk margin applied as a percentage of revenue prior to the directed payments and the 2.0% premium tax allowance.
 - The composite capitation rates shown are based on DHHS projections of MCO enrollment for SFY 2023, which include considerations for the unwind process following the end of the Public Health Emergency (PHE) with enrollment returning to near pre-PHE levels by March 2023. It is likely in the future Amendment #9 that enrollment will need to be recalibrated if the federal government continues to extend the federal PHE.
- Included in the Appendix to this letter:
 - Table 1A shows the rate impact excluding directed payments, as well as with and without the SMI/SED (Severely Mentally Ill/Severely Emotionally Disturbed) 1115 waiver amendment to the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) Demonstration at 3.8% to the total composite rate.

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- o Table 1B takes into account directed payments and reflects a change of 1.8%.
- o Table 2 shows the component changes leading to the 1.8% increase in composite rate.
- o The price limitation is \$168,631,814 less than SFY 2022 (prior to any legislation enacted after the contract date).

2. Risk Mitigation Structure

- Retrospective acuity adjustment due to the uncertainty surrounding the continuous membership unwind process following the end of the PHE as authorized by the Center for Medicare and Medicaid Services (CMS) Division of Managed Care Policy on May 11, 2022. The purpose is to appropriately account for this uncertainty; DHHS will implement a non-budget neutral retroactive acuity adjustment to include a preliminary acuity assumption that will be updated following the contract year to reflect the actual population covered throughout SFY 2023; the preliminary risk adjustment for the expected enrollment composition changes the amount to an \$11.9 million increase.

- Minimum and maximum medical loss ratio (MLR) remains in effect for SFY 2023, to protect against a windfall or underfunding of services within the Program.

The minimum MLR is set on a program-wide basis for each major population, such that maximum profit achievable is 4%, which is equal to the 1.5% target margin plus the amount between the target MLR and the minimum MLR (2.5%). Based on the target MLRs, the minimum MLR will be 88.3% for the Standard Medicaid population and 87.6% for the GAHCP population.

The maximum MLR is also set on a program-wide basis for each major population 3.5% above the target MLR, such that MCOs will have a maximum loss of 2.0%. Based on the target MLRs the maximum MLR will be 94.3% for the Standard Medicaid population and 93.6% for the GAHCP population.

The final minimum and maximum MLRs for Standard Medicaid and GAHCP will be updated for the final retroactive acuity factor and any other changes implemented covering the amendment period starting January 2023.

- Other existing adjustment factors risk-neutral to the State continue in the Program. The risk mitigation structure is consistent with the structure included in the SFY 2022 capitation rates with the one modification to include a retrospective acuity adjustment that addresses uncertainty caused by the end of the PHE.
- On page 9 of the 2022-2023 Medicaid Managed Care Rate Development Guide, "CMS recommends all states implement a 2-sided risk mitigation strategy for rating periods impacted by the Public Health Emergency." Due to population and cost uncertainty related to the ongoing PHE and the anticipated enrollment redetermination process.

3. Other Program Rate Adjustments

- SFY 2023 component changes in Table 2 (see Appendix) are expressed relative to the same components in the SFY 2022 rates.
- Incorporation of the Institution for Mental Disease (IMD) SMI/SED Waiver effective July 1, 2022 (pending CMS approval), DHHS will implement its SMI/SED (Severely

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and the Honorable Council
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Mentally Ill/Severely Emotionally Disturbed) 1115 waiver amendment to the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) Demonstration.

The waiver amendment allows DHHS to claim additional federal matching funds for Medicaid enrollees aged 21 through 64 years treated in an Institution for Mental Disease (IMD), including at New Hampshire Hospital and Hampstead Hospital for lengths-of-stay greater than 15 days and no more than 60 days for an individual (the average length-of-stay for all beneficiaries cannot exceed 30 days).

- Medical trend adjustment since the start of the COVID-19 pandemic and PHE, service utilization levels in the Medicaid program have lagged behind CY 2019 utilization by rate cell and on an aggregate basis; therefore, capitation rates assume SFY 2023 utilization levels will be consistent with CY 2019. As such, utilization trends from CY 2019 to SFY 2023 remain constant with the exception of Applied Behavioral Analysis (ABA) services with an annual trend rate from CY 2019 to SFY 2023 at 21.7%. ABA services are an evidence-based consultation, assessment and treatment option for children with autism spectrum disorder or other developmental conditions that can improve social, communication, and learning skills.
- Preliminary acuity adjustment is an increase because it reduces costs by a lower amount in SFY 2023 than SFY 2022 largely due to the current estimate of enrollment timing and trajectory during the PHE unwind.
- Pharmacy trend and savings. The pharmacy trend assumptions in Table 2 are based on a combination of historical New Hampshire Medicaid data analysis, Milliman's research on utilization and cost trends, and publicly available trend reports and forecasts.

Pharmacy savings were shown in the preferred drug list (PDL) analysis. The pharmacy savings analysis undertaken for this amendment included savings related to adjustments for prescribing efficiency opportunities for several drug classes related to asthma, HIV, and autoimmune disorders. The savings amounted to \$907,740 for the rating period, though the savings were less than SFY 2022 resulting in a cost increase for this line item. Lastly, the J-code class of injectable drugs reflects market trends.

- Opioid addiction treatment trend adjustment to the base experience data underlying the MCM capitation rates to account for the estimated change in both prevalence and cost of treatment for the opioid addiction treatment population. Based on the Actuary's review of SFY 2015 through October 2021 MCO encounter data, they determined the proportion of opioid addiction population started to decrease for several rate cells. This decrease in the proportion of opioid addiction population results in adjustments of less than 1.00 for several rate cells.
- Directed payment adjustment to remove the completed SFY 2022 HCBS (Home and Community Based Service) payments related to time limited American Rescue Plan enhanced FMAP for HCBS.
- Funding for 14 additional Community Residential Beds coming into service. Expanded services to fund an additional 14-bed community residential services at roughly \$958,000 (including administration, premium tax and margin).

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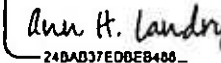
- Reimbursement adjustments to reflect recent or expected changes in the Medicaid Fee-for-Service (FFS) provider fee schedule based on Medicare Fee Schedule changes including:
 - Current Ambulatory Surgical Center fee schedule effective January 1, 2022;
 - Professional and other services fee schedules effective January 1, 2022; and
 - J-code repricing effective July 1, 2022, and other routine fee schedule updates.

- Other adjustments included in the rate change driver table (Table 2) for the SFY 2023 rates:
 - Base data update (e.g., lower/higher incurred but not reported (IBNR) expenses than previously estimated);
 - Enrollment projection impact on fixed dollar items (e.g., Community Mental Health Agreement funding);
 - Changes in FFS fee schedule from SFY 2022 to SFY 2023;
 - Refreshed financial data items from the MCOs (e.g., provider incentive payments);
 - Changes in enrollment information (e.g., retroactive change in rate cell assignment);
 - Changes in stop loss attachment point for high-cost member claims; and
 - Changes in program effective dates (e.g., Behavioral Health Crisis Treatment Centers (BHCTC), genetic testing)

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session. In the event the contract is not approved before June 30, 2022, the available federally permitted retroactive risk adjustment mitigation to account for the uncertainty of the PHE unwind will not be available to New Hampshire.

Respectfully submitted,

DocuSigned by:

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Lori A. Shibinette
Commissioner

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and the Honorable Council
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APPENDIX

Table 1A
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Excluding Directed Payments

Population	SFY 2022	SFY 2023		Percentage Change	
		Excluding Impact of SMI/SED 1115 Waiver Amendment	Total	Excluding Impact of SMI/SED 1115 Waiver Amendment	Total
Standard Medicaid					
Base Population	\$328.56	\$344.83	\$348.28	5.0%	5.4%
CHIP	192.68	213.67	214.07	10.9%	11.1%
Behavioral Health Population	1,381.53	1,408.40	1,461.70	1.9%	5.8%
Total Standard Medicaid	\$384.19	\$401.87	\$406.85	4.6%	5.9%
Granite Advantage Health Care Program					
Medically Frail	\$1,091.37	\$1,093.39	\$1,097.65	0.2%	0.6%
Non-Medically Frail	418.97	418.07	419.51	-0.2%	0.1%
Behavioral Health Population	1,933.60	1,951.04	2,033.28	0.9%	5.2%
Total GAHCP	\$583.17	\$583.42	\$588.33	0.0%	0.9%
Grand Total	\$441.88	\$453.94	\$458.90	2.7%	3.8%

Table 1B
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2023 Capitation Rate Change
Based on Projected SFY 2023 Enrollment by Rate Cell
Including Directed Payments

Population	SFY 2022	SFY 2023		Percentage Change	
		Excluding Impact of SMI/SED 1115 Waiver Amendment	Total	Excluding Impact of SMI/SED 1115 Waiver Amendment	Total
Standard Medicaid					
Base Population	\$352.95	\$356.71	\$358.17	1.1%	1.5%
CHIP	198.39	219.27	219.67	10.5%	10.7%
Behavioral Health Population	1,470.78	1,484.33	1,517.68	-0.4%	3.2%
Total Standard Medicaid	\$410.57	\$416.00	\$420.88	1.3%	2.5%
Granite Advantage Health Care Program					
Medically Frail	\$1,144.47	\$1,146.77	\$1,150.99	0.2%	0.6%
Non-Medically Frail	432.79	431.13	432.57	-0.4%	-0.1%
Behavioral Health Population	2,001.29	1,992.81	2,075.12	-0.4%	3.7%
Total GAHCP	\$583.63	\$582.21	\$587.11	-0.2%	0.6%
Grand Total	\$466.35	\$469.57	\$474.53	0.7%	1.8%

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and the Honorable Council
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Table 2 New Hampshire Department of Health and Human Services SFY 2023 MCM Capitation Rate Change by Component ¹ Based on Projected SFY 2023 Enrollment by Rate Coll						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Inclusion of IMD admissions of less than 60 days for age 21-64 population as a covered Medicaid service through SMI/SED 1115 waiver amendment to the SUD-TRA 1115 demonstration						
Newly covered New Hampshire Hospital (NH) admissions repriced at NHH minimum fee schedule	1.1%	\$7,703,888	0.8%	\$3,755,578	1.0%	\$11,459,465
Reversal of IMD exclusion for other impacted services	0.1%	\$672,069	0.0%	\$163,043	0.1%	\$835,112
Total impact of SMI/SED 1115 waiver amendment	1.2%	\$8,375,957	0.8%	\$3,918,620	1.1%	\$12,294,578
Other program changes						
New Hampshire and Hampstead Hospitals – repricing to minimum fee schedule for services historically covered by MCM program	0.5%	\$3,450,993	0.1%	\$365,521	0.3%	\$3,816,514
Community residential services – additional beds	0.1%	745,993	0.0%	121,129	0.1%	867,123
Preliminary SFY 2023 acuity adjustment compared to SFY 2022 acuity assumption	0.7%	4,769,045	1.5%	7,211,955	1.0%	11,981,000
Total other program changes	1.3%	\$8,966,032	1.6%	\$7,698,605	1.4%	\$16,664,636
Other changes relative to SFY 2022 rating assumptions						
Non-pharmacy utilization trends	-1.1%	(7,844,706)	-1.1%	(5,248,839)	-1.1%	(13,093,545)
Opioid addiction treatment trend adjustment	-0.5%	(3,148,990)	-0.8%	(3,909,040)	-0.6%	(7,058,031)
Inpatient and outpatient hospital unit cost trends	0.5%	3,184,479	0.6%	2,980,746	0.5%	6,165,225
Applied behavioral analysis service trends	1.1%	7,450,186	0.0%	5,939	0.6%	7,456,105
Pharmacy trends	2.4%	16,751,556	0.3%	1,296,337	1.6%	18,047,893
Preferred drug list (PDL) adjustment	-0.1%	(1,000,190)	-0.9%	(4,036,173)	-0.4%	(5,036,363)
Pharmacy savings initiatives	0.0%	121,825	0.1%	406,868	0.0%	528,693
J Code fee schedule changes	0.1%	1,033,584	0.2%	991,855	0.2%	2,025,439
Boston Children's Hospital risk pool funding level	0.3%	1,955,549	0.0%	34,726	0.2%	1,990,275
Other	0.3%	2,227,495	0.0%	(21,256)	0.2%	2,206,240
Total Other Changes	3.0%	\$20,732,768	-1.6%	(\$7,498,837)	1.1%	\$13,233,931
Total rate change for SFY 2023 relative to SFY 2022 rates (prior to directed payment changes)						
	5.5%	\$38,074,756	0.9%	\$4,118,388	3.6%	\$42,193,145
Directed payment changes						
Removal of HCBS directed payment	-3.3%	(23,012,503)	-0.7%	(3,377,214)	-2.3%	(26,389,717)
Impact of enrollment decrease on the PMPM value of fixed-dollar directed payments ²	0.4%	2,431,500	0.4%	2,047,234	0.4%	4,478,733
Total directed payment changes	-3.0%	(\$20,581,003)	-0.3%	(\$1,329,981)	-1.9%	(\$21,910,984)
Total rate change for SFY 2023 relative to SFY 2022 rates (after directed payment changes)						
	2.5%	\$17,493,753	0.6%	\$2,788,408	1.8%	\$20,282,161

¹ The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.
² The SFY 2023 directed payments remain at \$33 million for critical access hospitals and \$5 million for CMHCs. Lower projected enrollment for SFY 2023 compared to SFY 2022 results in higher PMPM amounts to fund the directed payments.

His Excellency, Governor Christopher T. Sununu,
and the Honorable Council
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**Medicaid Care Management Services Contract
Amendment #8 Fiscal Details**

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND					
State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	\$575,768,481		\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	\$0	\$446,902,230	\$446,902,230
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,417,947,033	\$446,902,230	\$1,864,849,263
05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION MEDICAID SERVICES, OFC OF MEDICAID SERVICES CHILD HEALTH INSURANCE PROGRAM					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$102,351,504		\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	\$0	\$102,152,951	\$102,152,951
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$221,225,863	\$102,152,951	\$323,378,814
05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: DIVISION OF MEDICAID SERVICES, OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$618,433,737		\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	\$0	\$578,866,727	\$578,866,727
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,706,620,882	\$578,866,727	\$2,285,487,609
		Total Funds	\$3,345,793,778	\$1,127,921,908	\$4,473,715,686



Lori A. Shibanette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

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December 2, 2021

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into **Retroactive** amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total price limitation by \$107,893,151 from \$3,237,900,627 to \$3,345,793,778, with no change to the completion date of August 31, 2024, and effective retroactive to July 1, 2021 upon Governor and Council approval. Funding sources are as follows:

	Federal	Other	General
<i>Granite Advantage Health Program (GAHCP)</i>	90%	10% (as defined in RSA 126-AA:3, I)	0%
<i>Child Health Insurance Program (CHIP)</i>	67.40%	0%	32.60%
<i>Standard Medicaid Population (Medicaid Care Management)</i>	53.57%	0%	46.43%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of FMAP for the Children's Health Insurance Program (CHIP) population remains available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. Additionally, the American Rescue Plan of 2021 potentially provides an additional 10% FMAP for a one year period (April 1, 2021-March 31, 2022) for certain home and community based services (HCBS) covered in this contract based on an approved Centers for Medicare and Medicaid Services (CMS) HCBS spending plan. The Department will request Fiscal Committee approval to accept and expend additional amounts for January 2022 forward. The adjusted price limitation, given the enhanced FMAP and provisions in HB 2, should be sufficient to stay within the budget for SFY 2022. Legislation under consideration by Congress could impact the CHIP and Standard Federal share amounts.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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(Item #6), January 22, 2021 (Item #9), and as amended on June 30, 2021 (Item # Tabled Item 8A).

Funds are available in the accounts outlined in the attached fiscal details and are anticipated to be available in the State Fiscal Year (SFY)2022, with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

CMS requires managed care rate certifications be completed on a 12-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2022.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, as well as enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes, and legislatively approved rate increases are also included.

EXPLANATION

This request is **Retroactive** because it covers the rating period of July 1, 2021, through June 30, 2022. There are three key purposes for this amendment:

- First, is to incorporate the impact of acuity (i.e., the measure of beneficiaries' collective medical conditions) due to an increase in new enrollment as the result of an extended federal public health emergency and extended continuous enrollment. Generally, there has been a decrease in acuity that moderates claims expense costs compared to the rates approved under Amendment #6;
- Second, is to incorporate the increased costs of legislative changes from both federal legislation and state actions in the most recent legislative session; and
- Third, is to incorporate fee schedule updates, and an adjustment for pharmacy management.

Further Explanation

Amendment #7 adjusts the SFY 2022 capitation rates. The Department's contracted actuary, Milliman, projects an overall MCO medical loss ratio (MLR) for at-risk services of 90.7% for the Standard Medicaid population and 90.0% for the GAHCP population in SFY 2022, which includes the rate development highlights below.

Milliman used the following methodology to develop the New Hampshire MCM program capitation rates:

1. Rate methodology

The methodology used to develop the Amendment #7 SFY 2022 MCM capitation rates is consistent with the Amendment #6 capitation rate methodology.

2. Changes in enrollment

CMS instructed the Department to review emerging enrollment and Public Health Emergency (PHE) conditions for Amendment #7. The updated capitation rates are based

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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on the Department's updated projections of MCO enrollment for SFY 2022 which include continued enrollment growth through SFY 2022.

3. Acuity adjustment

For the Amendment #7 SFY 2022 MCM capitation rates, Milliman updated the acuity adjustment factors taking into account the nature of the new enrollment compared to historical enrolled individuals.

4. Federal and State Legislative actions

a. Home and community based services (HCBS) enhanced federal funding

HCBS directed payments available under Section 9817 of the American Rescue Plan Act (ARPA) provide enhanced federal funding for state Medicaid spending on home and community based services. Beginning April 1, 2021, through March 31, 2022, states are eligible to receive a ten (10) percentage point increase in their FMAP for specified HCBS services. In order to claim the enhanced FMAP eligible under the MCO contracts, the Department is proposing to implement a new directed payment initiative estimated at \$28 million for certain eligible HCBS state plan services (pending CMS approval). Rates for directed payments do not include an additional allowance for administrative expense or risk margin for this addition. The directed payment is subject to premium tax.

b. State Legislative benefit updates

i. Home visiting services for pregnant women and infants ages 0-1 year consistent with HB 2 beginning October 1, 2021, were prorated 9-months at estimated annual costs of \$1.853 million.

ii. Genetic testing reimbursement for hospitals in accordance with HB 600.

5. Fee schedule updates, include:

a. DRG inpatient hospital unit cost trend updates using the actual 2022 DRG weights effective October 1, 2021. A review of the newly released weights suggests a 0.0% unit cost trend between 2021 and 2022 compared to the Amendment #6 assumption of a 0.56% increase based on historical data.

b. Neuro-psychiatric testing codes within the Calendar Year 2021 fee schedule included a number of incorrect entries for several neuro-psychiatric testing codes which prompted an update to reimbursement adjustment factors. The estimated impact of the correction is an increase of approximately \$135,000 for SFY 2022.

c. Other fee schedule changes, include:

i. Unit cost adjustment for latex gloves and a fee schedule update for vaccine administration account for an additional \$310,000 in SFY 2022.

ii. New durable medical equipment (DME) and supplies (breast milk storage bags, peristeen pumps) with annual costs estimated at \$280,200 and \$135,000, respectively (effective October 1, 2021).

iii. Behavioral health crisis treatment center program services transferring to the State's redesigned Mobile Crisis Response Program.

His Excellency, Governor Christopher T. Sununu
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- iv. Preferred drug list (PDL) updates to include different formulations of drugs already included on the PDL.
- v. Community residential services beds service projection updates.

6. Prescription drug savings adjustments

An adjustment to rates is included to account for differences in MCO pharmacy management (e.g., adherence to generally accepted quantity limits for three (3) therapeutic classes, opioid prescribing patterns, prior authorization denial rates) with annual savings of \$1.59 million incorporated into the rates.

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP are insufficient to cover the program, the projected shortfall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session. In the event the contract is not approved, available federal relief to HCBS providers and their direct care workers would not be available.

Respectfully submitted,



Lori A. Shibinette
Commissioner

Medicaid Care Management Services Contract Amendment #7 Fiscal Details

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, GRANTEE ADVANTAGE HEALTH PROGRAM TRUST FUND					
State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	\$478,176,246	\$97,592,235	\$575,768,481
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,320,354,798	\$97,592,235	\$1,417,947,033
05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	\$105,226,028	(\$2,874,524)	\$102,351,504
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$224,100,386	(\$2,874,524)	\$221,225,863
05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT					
State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	\$605,258,297	\$13,175,440	\$618,433,737
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
		<i>Sub-Total</i>	\$1,693,445,442	\$13,175,440	\$1,706,620,882
		<i>Amendment #7</i>	Current Budget	Increase / (Decrease)	Revised Budget
		Total Funds	\$3,237,900,627	\$107,893,151	\$3,345,793,778

**Medicaid Care Management Services Contract
Amendment #7 Fiscal Details**

Table 1A			
New Hampshire Department of Health and Human Services			
Medicaid Care Management Program			
SFY 2022 Capitation Rate Change			
Based on Projected SFY 2022 Enrollment by Rate Cell			
Excluding Directed Payments			
Amendment #6 SFY 2022			
Population	Capitation Rate (assuming PHE ends in December 2021)	Amendment #7 SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$333.44	\$329.75	-1.1%
CHIP	198.87	196.50	-1.2%
Behavioral Health Population	1,362.27	1,369.33	0.5%
Total Standard Medicaid	\$393.22	\$390.53	-0.7%
Granite Advantage Health Care Program			
Medically Frail	\$1,102.60	\$1,091.37	-1.0%
Non-Medically Frail	434.71	418.97	-3.6%
Behavioral Health Population	1,924.66	1,937.48	0.7%
Total GAHCP	\$584.51	\$569.64	-2.5%
Grand Total	\$462.92	\$455.79	-1.5%

Table 1B			
New Hampshire Department of Health and Human Services			
Medicaid Care Management Program			
SFY 2022 Capitation Rate Change			
Based on Projected SFY 2022 Enrollment by Rate Cell			
Including Directed Payments			
Amendment #6 SFY 2022			
Population	Capitation Rate (assuming the PHE ends in December 2021)	Amendment #7 SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$344.61	\$354.31	2.8%
CHIP	204.22	202.50	-0.8%
Behavioral Health Population	1,413.46	1,457.38	3.1%
Total Standard Medicaid	\$406.64	\$417.37	2.6%
Granite Advantage Health Care Program			
Medically Frail	\$1,154.24	\$1,144.47	-0.8%
Non-Medically Frail	449.47	432.79	-3.7%
Behavioral Health Population	1,960.95	2,005.23	2.3%
Total GAHCP	\$604.49	\$590.37	-2.3%
Grand Total	\$478.73	\$480.41	0.3%

**Medicaid Care Management Services Contract
Amendment #7 Fiscal Details**

Table 2 New Hampshire Department of Health and Human Services Amendment #6 vs Amendment #7 SFY 2022 MCM Capitation Rate Change by Component Based on Projected SFY 2022 Enrollment by Rate Cell						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Program Changes						
Benefit Updates	0.2%	\$1,760,394	0.0%	\$114,928	0.1%	\$1,875,322
Allowance for Genetic Testing for Hospitals per HB 600	0.0%	120,592	0.0%		0.0%	120,592
Behavioral Health Crisis Treatment Center Update	0.0%	(28,652)	0.0%	(87,990)	0.0%	(116,642)
Home and Community Based Services Directed Payment (TBD)	3.4%	24,176,318	0.7%	4,334,931	2.2%	28,511,250
Total Program Changes	3.7%	\$26,028,652	0.7%	\$4,361,870	2.3%	\$30,390,522
Other Changes Relative to Amendment #6 Rating Assumptions						
Fee Schedule and DRG Trend Updates	0.0%	\$136,594	0.0%	(\$163,400)	0.0%	(\$26,805)
Update to Community Residential Services Bed Projections	0.0%	38,651	0.0%	6,452	0.0%	45,104
PDL Update	0.0%	128,414	0.0%	(74,195)	0.0%	54,219
Acuity Adjustment Update	-0.7%	(4,885,580)	-1.8%	(11,050,153)	-1.2%	(15,935,733)
Prescription Drug Savings	-0.1%	(974,522)	-0.2%	(1,165,118)	-0.2%	(2,139,640)
PMPM Impact of Updated Enrollment Projections on Fixed Dollar Rate Components	-0.3%	(1,826,101)	-1.0%	(5,986,171)	-0.6%	(7,812,272)
Total Other Changes	-1.0%	(\$7,382,543)	-3.1%	(\$18,432,585)	-2.0%	(\$25,815,127)
Total Rate Change for SFY 2022 Relative to Amendment #6 Rates	2.6%	\$18,646,109	-2.3%	(\$14,070,715)	0.3%	\$4,575,394

The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.

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**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES**

Lori A. Shibley
Commissioner

Henry D. Lipman
Director

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May 27, 2021

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by increasing the total shared price limitation by \$1,188,660,571 from \$2,049,240,056 to \$3,237,900,627, with no change to the completion date of August 31, 2024 effective July 1, 2021 or upon Governor and Council approval, whichever is later. Funding sources are as follows:

	Federal	Other	General
Granite Advantage Health Program (GAHCP)	90%	10% (as defined in RSA 126-AA:3, I)	0%
Child Health Insurance Program (CHIP)	71.88%	0.50%	27.62%
Standard Medicaid Population (Medicaid Care Management Account)	53.12%	22.56%	24.32%

NOTE: An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population and 4.34% of federal medical assistance percentage (FMAP) for the CHIP population could become available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. Additionally, the American Rescue Plan of 2021 potentially provides an additional 10% FMAP for a one year period (April 1, 2021-March 31, 2022) for certain home and community based services covered in this contract based on approved Centers for Medicare and Medicaid Services (CMS) spending plan, which is subject to further federal guidance at this juncture. If the additional funding is received the Department will request Fiscal Committee authority to accept, and expend additional amounts for January 2022 forward.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 2 of 5

April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), June 10, 2020 (Item #6), and January 22, 2021 (Item #9).

Funds are available in the accounts outlined in the attached fiscal details for State Fiscal Year (SFY) 2021, and are anticipated to be available in the SFYs 2022 through 2023 with authority to adjust amounts within the price limitation between SFYs through the Budget Office, if needed and justified.

CMS requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each SFY and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the Legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for SFYs 2020-2023.

See attached fiscal details.

Fiscal table budget amounts reflect more current utilization and enrollment experience, enhanced FMAP available and accepted to date. Adjustments to administrative costs, program changes and legislatively approved rate increases are included as well.

EXPLANATION

This request covers the rating period of July 1, 2021 through June 30, 2022.

Summary of Key Changes

Exhibit A. Program Change Summary:

1. A carry forward of staffing requirements from amendment #5
2. Added provision that Members shall not be required to change covered prescription drugs more than once per calendar year, with limited exceptions.
3. Further extension of additional preferential auto-assignment awards for high-performing MCO(s) consistent with Alvarez & Marsal's report recommendation incorporated initially the last MCO contract amendment.
4. New CMS Managed Care Rule provisions effective July 1, 2021 concerning beneficiary/member rights.
5. Update to the National Committee for Quality Assurance (NCQA) reporting compliance requirements.
6. New Directed Payment for Community Residential Services provided by Community Mental Health Centers (CMHCs) and Psychiatric Designated Receiving Facilities (DRFs); continuation of Directed Payments for Durable Medical Equipment (DME), CMHCs, and Critical Access Hospitals (CAHs).
7. The inclusion of CMS requested language for historical directed payments terms.
8. Elimination of risk corridor and replacement with Minimum and Maximum Medical Loss Ratios (MLRs), the effect of which reduces the state's risk compared to the SFY 2020 and 2021 Risk Corridors. The state has greater enrollment risk due to the unpredictable length of the federal public health emergency.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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9. The minimum MLR is set at 88.2% for the Standard Medicaid population and 87.4% for the Granite Advantage Health Care Program (GAHCP) population. The maximum MLR shall be 94.2% for the Standard Medicaid population and 93.4% for the GAHCP population.

10. Any incentive payments made to higher-performing MCOs as part of the Withhold and Incentive Program shall not impact the minimum or maximum MLR provision of the contract.

11. For the period July 1, 2021 through June 30, 2022 rating period, MCOs will receive a one-time kick payment for each Member psychiatric admission stay with DRG code 880-887 subject to limited exceptions.

12. Sets the MCO administrative allowance for SFY 2022 at the 40th percentile, or \$35.78 PMPM (Per Member Per Month) SFY 21 had a blended administrative allowance of \$37.00 PMPM.

The state's actuary Milliman used the following methodology to develop the New Hampshire MCM program capitation rates:

1. Summarize CY 2018 and CY 2019 MCO encounter experience data for the Standard Medicaid and GAHCP Medically Frail eligible population and the March 2019 to December 2019 MCO encounter data for the GAHCP Non-Medically Frail population.
2. Project estimated statewide SFY 2022 MCM program medical costs for all covered services by rate cell.
3. Blend the projected SFY 2022 costs based on CY 2018 and CY 2019 encounter data.
4. Adjust SFY 2022 projected medical costs for all rate cells for benefits not included in the base experience data, expected administrative expenses, margin, and premium tax.

Medicaid enrollment is projected to remain elevated through the end of the federal Department of Health and Human Services declared PHE. There still exists uncertainty related to the end of the PHE. As such, Milliman prepared two (2) separate enrollment scenarios: 1) the PHE ends December 2021, and 2) the PHE ends September 2021:

- Each scenario assumes enrollment returning to pre-COVID levels due to the reinstatement of eligibility redetermination activities three (3) months following the end of the PHE.
- The changes in enrollment are anticipated to impact the average acuity of beneficiaries. For rate cells modeled to have significant enrollment differences due to the PHE; newer enrollees having lower illness burden, the rate development includes an acuity adjustment for each scenario.
- The Department will initially pay capitation rates based on the December 2021 scenario, but will retroactively pay capitation rates under the September 2021 scenario if the PHE ends prior to October 1, 2021.

The capitation rates do not include provisions for expected vaccination administration fees related to COVID-19 in SFY 2022. The cost of vaccination administration fees remain carved out of the MCM program. Based on the interplay of other funding sources. The SFY 2022 capitation rates do not include any explicit adjustments for the following:

- COVID-19 Testing and Treatment Cost: The prevalence of COVID-19 infection rates in SFY 2022 is dependent on many variables that make it difficult to predict to include an

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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estimate for the cost of testing for and treating individuals with COVID-19 including, but not limited to:

- The take-up rate and timing of COVID-19 vaccinations;
- The emergence of COVID-19 variants and the efficacy of vaccines on these variants; and
- The implementation of social distancing measures.

Milliman advises, there is not a publicly available model that includes COVID-19 infection rate or hospital admissions through June 2022. In addition, the publicly available models have materially changed short-term and long-term projections of COVID-19 prevalence in reaction to emerging data. While Milliman reviewed historical MCM data for the cost of testing and treating COVID-19 in CY 2020, given the unpredictable patterns of COVID-19 prevalence to date in New Hampshire and the changing national models there is a range of potential impacts on the SFY 2022 rates.

The most significant fiscal impact of COVID-19 to date has been the deferral of non-essential services, either through government-enacted policies, the impact of social distancing on the administration of services, or personal choice. Milliman reviewed MCM emerging claims data incurred through February 2021 by population type (to remove the impact of membership mix changes). As of February 2021, there was still measurable reductions in claim costs for each population compared to the PMPMs prior to the pandemic in CY 2019. However, Milliman advises it is difficult to use this historical data to project the impact of deferred services for SFY 2022 for many reasons.

- Utilization by service category has varied in CY 2020 and early CY 2021 as the level of COVID-19 diagnoses and hospital admissions has changed in New Hampshire over the course of the pandemic. Therefore, the unknown future prevalence of COVID-19 will be a key variable in future service utilization changes relative to pre-pandemic levels.
- Limited data is available to understand how beneficiary behavior will change during and after the roll-out of the COVID-19 vaccination. As such, there could still be a wide range of possibilities as to when service utilization may return to pre-pandemic levels or if there will be increased utilization due to pent up demand.
- In the MCM data Milliman reviewed it is difficult to isolate the impact of deferred services from changes in utilization due to other drivers, such as member acuity changes or change in service mix.

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In response to the pandemic, the mix of services used to treat patients has changed, such as the use of telehealth services. It is unknown if these provider and patient changes will persist after the end of the pandemic.

Area served: Statewide.

In the event that the non-federal Other funds for the GAHCP necessary to cover the program are not sufficient, the projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shibinette
Commissioner

**Medicaid Care Management Services Contract
Amendment #6 Fiscal Details**

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$533,510,406		\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	TBD	\$478,176,246	\$478,176,246
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$842,178,552	\$478,176,246	\$1,320,354,798

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$63,005,695		\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	TBD	\$105,226,028	\$105,226,028
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$118,874,358	\$105,226,028	\$224,100,386

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$636,158,866		\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	TBD	\$605,258,297	\$605,258,297
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$1,088,187,145	\$605,258,297	\$1,693,445,442
Grand Total			\$2,049,240,056	\$1,188,660,571	\$3,237,900,627

**Medicaid Care Management Services Contract
Amendment #6 Fiscal Details**

Table 1A			
New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Excluding Directed Payments – PHE Ending December 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$323.46	\$334.52	3.4%
CHIP	183.38	196.79	7.3%
Behavioral Health Population	1,398.23	1,362.47	-2.6%
Total Standard Medicaid	\$387.45	\$395.22	2.0%
Restated Total Standard Medicaid¹	\$387.45	\$398.48	2.8%
Granite Advantage Health Care Program			
Medically Frail	\$1,201.72	\$1,102.08	-8.3%
Non-Medically Frail	456.03	434.66	-4.7%
Behavioral Health Population	1,966.46	1,883.55	-4.2%
Total GAHCP	\$604.71	\$577.79	-4.5%
Restated Total GAHCP¹	\$604.71	\$578.69	-4.3%
Grand Total	\$457.62	\$454.19	-0.8%
Restated Grand Total¹	\$457.62	\$456.68	-0.2%

¹ Removes community residential service costs from January 2021 to June 2021 capitation rates to allow for a consistent comparison since those service costs will move into a directed payment for SFY 2022.

Table 1B			
New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Excluding Directed Payments – PHE Ending September 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$321.40	\$334.56	4.1%
CHIP	182.99	197.56	8.0%
Behavioral Health Population	1,376.46	1,361.95	-1.1%
Total Standard Medicaid	\$379.07	\$390.43	3.0%
Restated Total Standard Medicaid¹	\$379.07	\$393.77	3.9%
Granite Advantage Health Care Program			
Medically Frail	\$1,201.72	\$1,124.54	-6.4%
Non-Medically Frail	456.03	442.13	-3.0%
Behavioral Health Population	1,966.55	1,923.25	-2.2%
Total GAHCP	\$606.10	\$589.77	-2.7%
Restated Total GAHCP¹	\$606.10	\$590.79	-2.5%
Grand Total	\$448.95	\$451.79	0.6%
Restated Grand Total¹	\$448.95	\$454.42	1.2%

¹ Removes community residential service costs from January 2021 to June 2021 capitation rates to allow for a consistent comparison since those service costs will move into a directed payment for SFY 2022.

**Medicaid Care Management Services Contract
Amendment #6 Fiscal Details**

Table 1C New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Including Directed Payments – PHE Ending December 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$334.19	\$345.73	3.5%
CHIP	188.46	202.02	7.2%
Behavioral Health Population	1,447.43	1,455.31	0.5%
Total Standard Medicaid	\$400.38	\$411.91	2.9%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.31	\$1,154.24	-6.6%
Non-Medically Frail	474.37	449.47	-5.2%
Behavioral Health Population	2,004.30	1,937.80	-3.3%
Total GAHCP	\$625.70	\$598.45	-4.4%
Grand Total	\$473.15	\$472.16	-0.2%

Table 1D New Hampshire Department of Health and Human Services Medicaid Care Management Program SFY 2022 Capitation Rate Change Based on Projected SFY 2022 Enrollment by Rate Cell Including Directed Payments – PHE Ending September 2021			
Population	January 2021 to June 2021 Capitation Rate	SFY 2022 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$332.13	\$346.06	4.2%
CHIP	188.05	202.92	7.9%
Behavioral Health Population	1,426.26	1,463.18	2.6%
Total Standard Medicaid	\$391.87	407.59	4.0%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.31	\$1,181.62	-4.4%
Non-Medically Frail	474.37	458.53	-3.3%
Behavioral Health Population	2,004.39	1,985.83	-0.9%
Total GAHCP	\$627.10	\$612.72	-2.3%
Grand Total	\$464.27	\$470.73	1.4%

Medicaid Care Management Services Contract Amendment #6 Fiscal Details

Table 2
New Hampshire Department of Health and Human Services
SFY 2022 MCM Capitation Rate Change by Component ¹
Based on Projected SFY 2022 Enrollment by Rate Cell
PHE Ending in December 2021

Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Program Changes						
MCRT / ES Services Carve Out	-0.4%	(\$2,511,022)	-0.3%	(\$1,340,348)	-0.3%	(\$3,851,370)
Change to Hospital Directed Payment ²	-0.1%	(399,878)	-0.1%	(354,365)	-0.1%	(754,243)
Increase to Community Residential Services Reimbursement Incorporated into New Directed Payment	0.3%	1,810,745	0.0%	174,077	0.2%	1,984,822
Total Program Changes	-0.2%	(\$1,100,155)	-0.3%	(\$1,520,636)	-0.2%	(\$2,620,791)
Other Changes Relative to January 2021 to June 2021 Rating Assumptions						
Administrative Allowance Increase	0.9%	\$6,083,179	0.9%	\$4,693,554	0.9%	\$10,776,732
Acuity Adjustment Related to Increased MCM Program Enrollment	-1.0%	(7,125,086)	-1.3%	(6,712,787)	-1.2%	(13,837,873)
Change to Boston Children's Hospital Funding	0.0%	102,338	0.0%	6,968	0.0%	109,306
Change to PDL Adjustment Assumptions	0.6%	4,011,893	0.3%	1,502,964	0.5%	5,514,857
Change to Prescription Drug Trend Assumptions	-1.0%	(7,104,913)	-2.1%	(10,731,192)	-1.5%	(17,836,105)
Change to Outpatient Reimbursement Trend Assumptions	0.6%	4,100,658	0.7%	3,320,370	0.6%	7,421,028
Removal of SFY 2021 COVID-19 Adjustment	2.8%	19,122,578	-0.6%	(2,883,904)	1.4%	16,238,674
Impact of MCO PBM Change	-0.4%	(2,622,185)	-0.5%	(2,876,315)	-0.4%	(5,298,501)
Minimum DME Fee Schedule Evaluation Approach	-0.8%	(5,684,056)	-0.6%	(2,958,499)	-0.7%	(8,642,555)
Base Data Change and Other	1.4%	9,840,615	-0.8%	(4,162,099)	0.5%	5,678,515
Total Other Changes	3.0%	\$20,725,018	-4.1%	(\$20,600,940)	0.0%	\$124,078
Total Rate Change for SFY 2022 Relative to January 2021 to June 2021 Rates	2.9%	\$19,624,863	-4.4%	(\$22,121,576)	-0.2%	(\$2,496,713)

¹ The various rate change components include the impact of attributed administrative allowance, risk / profit margin, and premium tax beyond the service costs alone.

² The change in hospital directed payment represents the incremental change from the \$33.7 million included in the SFY 2021 capitation rates. The total hospital directed payment is \$33 million for SFY 2022.



Lori A. Shibinette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAID SERVICES

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December 30, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services, to enter into **Retroactive** amendments to existing contracts with AmeriHealth Caritas New Hampshire Inc., Philadelphia, PA; Boston Medical Center Health Plan Inc., Charlestown, MA; and Granite State Health Plan Inc., Bedford NH, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), by decreasing the total shared price limitation by \$128,374,314 from \$2,177,614,370 to \$2,049,240,056, with no change to the completion date of August 31, 2024 effective retroactive to July 1, 2020 upon Governor and Council approval.

Funds for Granite Advantage Health Program (GAHCP) are 90% Federal and 10% Other (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 74.23% Federal and 25.77% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 52.5% Federal, 24.15% General and 23.35% Other funds. An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population could become available if the Public Health Emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. If the forgoing materialize, DHHS would go to the Fiscal Committee to increase, accept, and expend amounts for January 2021 forward.

The original contracts were approved by Governor and Council on March 27, 2019, (Tabled Late Item A). They were subsequently amended with Governor and Council approval on April 17, 2019, (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A), and most recently amended with Governor and Council approval on June 10, 2020 (Item #6).

Funds are available in the accounts outlined in the financial section for State Fiscal Year 2021, and are anticipated to be available in the State Fiscal Years 2022 through 2025, with authority to adjust amounts within the price limitation between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align with the state budget process is included in the chart of accounts exhibit that follows. For these reasons, expenditures for the program are identified only for State Fiscal Years 2020-2021.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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See attached fiscal details.

EXPLANATION

This request is **Retroactive** because this Amendment covers the retrospective rating period July 1, 2020 through June 30, 2021. The State negotiated in the original SFY2021 rates the opportunity to refresh actuarial estimates. The State was able to use this added flexibility from CMS due to the Public Health Emergency, uncertainties related to COVID-19 treatment and costs, and utilization impact on non-COVID services. The most material initial actuarial estimate was for the costs of deferred care from the prior contract period. As the Public Health Emergency has continued this became a key assumption to revisit as has the enrollment and the composition thereof.

Fiscal table budget amounts reflect more current utilization and enrollment experience, enhanced FMAP available and accepted thus far. Adjustments to administrative costs, program changes and legislatively approved rate increases are included as well.

CMS published a new Medicaid Managed Care rule in November 2020 with provisions effective either December 14, 2020 or July 1, 2021. Those provisions taking effect in December 2020 are incorporated herein and are procedural rather than economic in impact to this Agreement.

Summary of Key Changes

The reduction in price limitation reflects a slightly less steep enrollment growth based on the State of New Hampshire's employment recovery with a greater than expected length of the PHE and maintenance of effort required to earn the enhanced FMAP. DHHS had forecast average monthly enrollment for the contract year of just over 215,000 people, whereas based on experience DHHS now forecast about 208,000 people. This reduction along with a 3% reduction globally in the capitation rates to be paid to the MCOs accounts for the favorable price limitation change.

The 3% capitation rate reduction is a function of net changes; totaling \$38,077,712. The single largest favorable change is related to more favorable COVID-19 cost experience of \$30,774,811. Rather than a 1.2% increase in this SFY 21 period for care deferred care before June 30, 2020, the adjustment for the full twelve month period is a 1.3% decrease.

The second largest favorable adjustment is for MCO administrative costs of \$17,406,265 (or 2.5% of capitation excluding directed payments and premium tax) for the period of January through June, 2021. This reduction reflects an analysis of what the PHE has permitted the MCOs to implement under the contract, what is likely to be able to be advanced in this period given an extension of the PHE due to waves of COVID-19 surge as well as recalibration of those activities where the return on investment looks longer than anticipated back when the contract was developed.

These and other administrative allowance adjustments represent an adjusted administrative allowance consistent with the 50th percentile for the full period (previously, the 75th percentile) and the 32nd percentile for the last six months. Administrative cost benchmarks of other Medicaid managed care plans and within the MCM program were assessed by the state's actuaries.

Offsetting these two key favorable cost adjustments are increases related to the HB4 3.1% provider rate increase amounting to \$13,775,736 for the period January through June 2021 and an increase in the Boston Children's Hospital risk pool of \$4,847,238 for the full twelve month period

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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reflecting more recent reported experience, other changes can be seen in Table A. The resulting composite capitation rates can be seen in Table B; the net is a 3% reduction.

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 90% Federal and 10% Other; funds for the Child Health Insurance Program are 74.23% federal as appropriated by Congress and 25.77% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 52.50% Federal as appropriated by Congress, 24.15% General and 23.35% Other funds.

In the event that the non-federal Other funds for the GAHCP necessary to cover the program are not sufficient, the projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shibinette
Commissioner

Medicaid Care Management Services Contract Amendment #5 Fiscal Details

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	\$598,415,047	(\$64,904,641)	\$533,510,406
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$907,083,193	(\$64,094,641)	\$842,178,552

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	\$70,490,459	(\$7,484,764)	\$63,005,695
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$126,359,123	(\$7,484,764)	\$118,874,358

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	\$692,143,775	(\$55,984,909)	\$636,158,866
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$1,144,172,054	(\$55,984,909)	\$1,088,187,145
<i>Grand Total</i>			\$2,177,614,370	(\$128,374,314)	\$2,049,240,056

Medicaid Care Management Services Contract Amendment #5 Fiscal Details

Table A						
New Hampshire Department of Health and Human Services						
SFY 2021 MCM Capitation Rate Change by Component¹						
Based on Projected SFY 2021 Enrollment by Rate Cell						
Rate Component	Standard Medicaid		GAHCP		Total	
	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact	Rate Change	12 Month Dollar Impact
Program Changes						
2021 DRG fee schedule	0.0%	(\$247,823)	0.0%	(\$251,060)	0.0%	(\$498,883)
Stop loss attachment point indexing	0.0%	265,222	0.0%	-	0.0%	265,222
Removal of MCO psychiatric consult service	0.0%	(181,666)	0.0%	(128,796)	0.0%	(310,462)
Administrative allowance changes related to MCM contract restructuring and benchmarking	-1.3%	(9,169,440)	-1.5%	(8,236,825)	-1.4%	(17,406,265)
House Bill 4 3.1% provider rate increase	1.1%	7,860,466	1.1%	5,915,270	1.1%	13,775,736
Updated DME fee schedule	0.0%	99,383	0.0%	14,580	0.0%	113,962
Fee schedule changes related to Medicare	0.0%	(218,541)	0.0%	(211,407)	0.0%	(429,947)
Total Program Changes	-0.2%	(\$1,592,398)	-0.5%	(\$2,898,238)	-0.4%	(\$4,490,636)
Other Changes						
COVID adjustment impact	-3.8%	(\$26,877,600)	-0.7%	(\$3,897,211)	-2.5%	(\$30,774,811)
Increase to BCH risk pool	0.7%	4,782,251	0.0%	64,987	0.4%	4,847,238
Behavioral Health Crisis Treatment Center utilization adjustment	0.0%	(160,346)	0.0%	(20,322)	0.0%	(180,669)
PMPM recalibration of fixed dollar rate components	-0.1%	(464,544)	-0.1%	(416,071)	-0.1%	(880,615)
Enhanced TPL recoveries and cost avoidance activities	-0.1%	(881,248)	-0.1%	(705,194)	-0.1%	(1,586,442)
Enhanced PDL compliance	0.0%	(75,548)	0.0%	(83,591)	0.0%	(159,139)
Voluntary Psychiatric Admissions	0.1%	377,733	0.3%	1,542,363	0.2%	1,920,097
Base data change and other	-0.1%	(868,319)	-1.1%	(5,904,416)	-0.5%	(6,772,736)
Total Other Changes	-3.4%	(\$24,167,621)	-1.7%	(\$9,419,455)	-2.7%	(\$33,587,076)
Total Rate Change for SFY 2021 Relative to Original SFY 2021 Rates	-3.7%	(\$25,760,019)	-2.2%	(\$12,317,693)	-3.0%	(\$38,077,712)

¹ The various rate change components include the impact of attributed administrative allowance, risk / profit margin and premium tax beyond the service costs alone.

**Medicaid Care Management Services Contract
Amendment #5 Fiscal Details**

Table B					
New Hampshire Department of Health and Human Services					
Medicaid Care Management Program					
SFY 2021 Capitation Rate Change					
Based on Projected SFY 2021 Enrollment by Rate Cell¹					
Population	Original SFY 2021 Capitation Rate Adjusted for Enrollment Mix	Updated July 2020 to Dec 2020 Capitation Rate	Updated Jan 2021 to June 2021 Capitation Rate	Updated SFY 2021 Capitation Rate²	Percentage Change from Original SFY 2021 Rate
Standard Medicaid					
Base Population	\$350.81	\$336.50	\$336.84	\$336.68	-4.0%
CHIP	198.67	193.77	187.23	190.30	-4.2%
Behavioral Health Population	1,460.51	1,401.17	1,442.01	1,422.21	-2.6%
Total Standard Medicaid	\$418.14	\$402.24	\$403.36	\$402.82	-3.7%
Granite Advantage Health Care Program					
Medically Frail	\$1,273.88	\$1,246.34	\$1,236.31	\$1,241.25	-2.6%
Non-Medically Frail	486.18	481.16	474.37	477.49	-1.8%
Behavioral Health Population	2,086.30	2,097.98	1,996.27	2,010.49	-3.6%
Total GAHCP	\$664.64	\$655.36	\$644.82	\$649.69	-2.2%
Grand Total	\$499.20	\$483.07	\$484.85	\$484.00	-3.0%

¹ Projected enrollment reflects DHHS estimates provided on December 9, 2020, with 1,193,381 member months for July 2020 to December 2020 and 1,312,169 member months for January 2021 to June 2021.

² The updated SFY 2021 capitation rates are a blend of the July 2020 to December 2020 rates and the January 2021 to June 2021 rates based on projected member months by rate cell.

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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Lori A. Shibiactte
Commissioner

Henry D. Lipman
Director

May 26, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to retroactively amend existing agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schrafft's City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM), and by increasing the shared price limitation by \$1,361,049,281 from \$816,565,089 to an amount not to exceed \$2,177,614,370, with no change to the completion date of August 31, 2024, effective upon Governor and Executive Council approval.

Funds for Granite Advantage Health Program (GAHCP) are 90% Federal and 10% Other (as defined in RSA 126-AA:3, 1); funds for the Child Health Insurance Program are 67.88% Federal and 32.12% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51.01% Federal, 22.56% General and 26.43% Other funds. An additional 6.2% of federal medical assistance percentage (FMAP) for the standard Medicaid population could become available if the public health emergency (PHE) continues. The Cares Act provides increased FMAP through the quarter the PHE ends so long as the State meets the maintenance of effort requirements. The funding percentage of the Child Health Insurance Program (CHIP) is already subject to enhancement through September 2020; the CARES Act would enhance that to 80.84% if the PHE continues into the first quarter of State Fiscal Year 2021. If the forgoing materialize, DHHS would go to the Fiscal Committee to increase, accept, and expend amounts.

This agreement was originally approved by the Governor and Executive Council on March 27, 2019 (Tabled Late Item A), and subsequently amended on April 17, 2019 (Item #9), December 18, 2019 (Item #15), May 20, 2020 (Item #7A).

Funds are available in the following accounts for State Fiscal Year 2021, and are anticipated to be available in the State Fiscal Years 2022 through 2025, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for State Fiscal Year 2021.

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$308,668,146		\$308,668,146
SFY 2021	101-500729	Medical Payments to Providers	TBD	\$598,415,047	\$598,415,047
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$308,668,146	\$598,415,047	\$907,083,193

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$55,868,664		\$55,868,664
SFY 2021	101-500729	Medical Payments to Providers	TBD	\$70,490,459	\$70,490,459
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$55,868,664	\$70,490,459	\$126,359,123

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Current Budget	Increase / (Decrease)	Revised Budget
SFY 2020	101-500729	Medical Payments to Providers	\$452,028,279		\$452,028,279
SFY 2021	101-500729	Medical Payments to Providers	TBD	\$692,143,775	\$692,143,775
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$452,028,279	\$692,143,775	\$1,144,172,054
<i>Grand Total</i>			\$816,565,089	\$1,361,049,281	\$2,177,614,370

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 3 of 6

EXPLANATION

This request covers the period July 1, 2020 through June 30, 2021 (prior contract period was a ten month period). The amounts herein make an initial actuarial estimate for the costs of deferred care from the prior contract period. The budget amounts in the fiscal tables reflect enrollment experience and trend as a result of the public health emergency and the maintenance of effort requirements. Thus far through May 22, 2020, from the date of the PHE, total enrollment has increased overall by more than 7% with the Granite Advantage Health Care Program (GAHCP) over 11%. For State Fiscal Year 2021, enrollment is projected to increase additionally 5.3% for the standard population and 16.5% for the GAHCP.

There is undoubtedly, a high level of uncertainty for future COVID-19 treatment and testing costs, and the acuity of the spike in new enrollment due to the effects of the COVID-19 and the PHE and related economic conditions. Additionally, the impacts on future utilization and deferred care, unrelated to COVID-19 are not reliably known. Therefore, DHHS proposes a retroactive actuarial rate refresh based on experience from the first quarter of the contract back to July 1, 2020 to incorporate more recent actuarial experience, HB 4 rate adjustments, and any further legislative policy changes. The retroactive actuarial rate refresh will necessitate another contract amendment anticipated in February 2021.

Summary of Changes

The amendment to the three (3) MCM capitated and risk-based vendor Agreements, including capitation rate adjustments for September 2019 to June 2020, and July 2020 through June 2021, as well as Exhibit A narrative contract changes, reflect the following changes:

The State Fiscal Year 2021 capitation rates below reflect three program changes from the September 2019 to June 2020 capitation rates.

They are:

1. Revised rate cell structure that incorporates the GAHCP Behavioral Health population into the existing Behavioral Health rate cells and a separate Children's Health Insurance Program (CHIP) rate cell;
2. Targeted savings opportunities through increased care management activities consistent with the MCM contract effective September 1, 2019; and
3. Implementation of a hospital directed payment to promote access to high-quality acute care services provided by critical access and non-critical access hospitals across New Hampshire.

The State Fiscal Year 2021 capitation rates include a continued five million dollar directed payment to community mental health centers (CMHCs), and a new thirty million dollar directed payment to hospitals (both subject to CMS approval). While the amounts are included in the MCO capitation rates, the MCOs are not at-risk for the amount of these directed payments. Both directed payments are included to support quality and access initiatives of the MCM Program.

Capitation Rate Tables 1A and 1B below show the statewide rate change by population compared to the September 2019 to June 2020 capitation rates included in the April 22, 2020 rate certification. The two tables compare rates with and without the new hospital directed payment.

Table 1A capitation rates exclude the new hospital directed payment.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Table 1A
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2021 Capitation Rate Change
Based on Projected SFY 2021 Enrollment by Rate Cell
Excluding Hospital Directed Payment

Population	September 2019 to June 2020 Capitation Rate	SFY 2021 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$329.36	\$342.73	4.1%
CHIP*	199.95	196.42	-1.8%
Behavioral Health Population	1,445.57	1,430.00	-1.1%
Total Standard Medicaid	\$405.24	\$414.21	2.2%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.85	\$1,239.29	0.2%
Non-Medically Frail	475.21	467.84	-1.6%
Behavioral Health Population**	999.67	2,046.46	104.7%
Total GAHCP	\$621.60	\$651.65	4.8%
Grand Total	\$469.36	\$484.58	3.2%

*The September 2019 to June 2020 capitation rates did not have a separate rate cell for the CHIP population. Most CHIP members were included in the Low Income Children and SED rate cells. The SFY 2021 CHIP population includes CHIP members enrolled in the CHIP and SED rate cells.

**The September 2019 to June 2020 GAHCP capitation rates did not have a separate rate cell for the GAHCP behavioral health population. GAHCP behavioral health population members were included in the Medically Frail and Non-Medically Frail capitation rates. The GAHCP behavioral health population will receive the behavioral health population capitation rates for SFY 2021.

Table 1B includes capitation rates with inclusion of the new hospital directed payment.

Table 1B
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
SFY 2021 Capitation Rate Change
Based on Projected SFY 2021 Enrollment by Rate Cell
Including Hospital Directed Payment

Population	September 2019 to June 2020 Capitation Rate	SFY 2021 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$329.36	\$353.36	7.3%
CHIP*	199.95	200.30	0.2%
Behavioral Health Population	1,445.57	1,446.23	0.0%
Total Standard Medicaid	\$405.24	\$424.48	4.7%
Granite Advantage Health Care Program			
Medically Frail	\$1,236.85	\$1,273.88	3.0%
Non-Medically Frail	475.21	486.18	2.3%
Behavioral Health Population**	999.67	2,069.51	107.0%
Total GAHCP	\$621.60	\$672.86	8.2%
Grand Total	\$469.36	\$498.09	6.1%

*The September 2019 to June 2020 capitation rates did not have a separate rate cell for the CHIP population. Most CHIP members were included in the Low Income Children and SED rate cells. The SFY 2021 CHIP population includes CHIP members enrolled in the CHIP and SED rate cells.

**The September 2019 to June 2020 GAHCP capitation rates did not have a separate rate cell for the GAHCP behavioral health population. GAHCP behavioral health population members were included in the Medically Frail and Non-Medically Frail capitation rates. The GAHCP behavioral health population will receive the behavioral health population capitation rates for SFY 2021.

It should be emphasized that capitation rates are a projection of future costs for an efficient MCO based on a set of assumptions. Actual MCO costs will be dependent on each MCO's

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 5 of 6

situation and the extent to which future experience conforms to the assumptions made in the capitation rate development calculations.

The amendment also includes narrative and other content changes as described below.

They include:

1. Transitional housing program services and community residential services wrap-around services and supports benefit start date from July 1, 2020 to July 1, 2021;
2. Reference to payments standards for directed payments described in actuarial certification materials for the rating period;
3. Change in delivery timeframes for DHHS notice of MCM Withhold and Incentive Program Guidance from within ninety (90) calendar days of the start of the program year to August 1st each year;
4. Explanation that any differences in performance and rating periods shall be described in the program's actuarial certification for the rating period;
5. With alternate instructions from CMS, full replacement of CMS-mandated contract language that directs administration and funds previously appropriated for the GAHCP community engagement requirements administered through the managed care contracts;
6. Provision for a retroactive rate refresh effective July 1, 2020 targeted for February 2021 to address the PHE and related economic and healthcare conditions;
7. Inclusion of a risk corridor protection for the July 2020 to June 2021 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic and the PHE; and
8. Technical corrections to Exhibit N (Liquidated Damages) referenced contract provisions.

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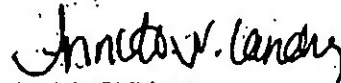
His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 6 of 6

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 90% Federal and 10% Other; funds for the Child Health Insurance Program are 67.88% federal as appropriated by Congress and 32.12% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51.01% Federal as appropriated by Congress, 22.56% General and 26.43% Other funds.

In the event that the non-federal Other funds for the GAHCP necessary to cover the program are not sufficient, the projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



For Lori A. Shibinette
Commissioner



Lori A. Shilbnette
Commissioner

Henry D. Lipman
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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April 24, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to **retroactively** amend existing agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schrafft's City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management (MCM). The shared price limitation remains unchanged, not to exceed \$816,565,089, in State Fiscal Year 2020, retroactive to September 1, 2019 with no change to the completion date of August 31, 2024, effective upon Governor and Executive Council approval. After reconciliation of membership, however, we did a reallocation of funds within the price limitation as reflected in the accounting tables.

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 77.6% Federal and 22.4% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 22.7% General and 26.3% Other funds.

This agreement was originally approved by the Governor and Executive Council on March 27, 2019 (Tabled Late Item A); and subsequently amended on April 17, 2019 (Item #9), and December 18, 2019 (Item #15).

Funds are available in the following accounts for State Fiscal Year 2020, and are anticipated to be available in the State Fiscal Years 2021 through 2025, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for State Fiscal Year 2020.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 2 of 6

**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$316,129,763	(\$7,461,617)	\$308,668,146
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$316,129,763	(\$7,461,617)	\$308,668,146

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$55,047,886	\$820,778	\$55,868,664
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$55,047,886	\$820,778	\$55,868,664

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$445,387,440	\$6,640,839	\$452,028,279
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$445,387,440	\$6,640,839	\$452,028,279

Grand Total	\$816,565,089	\$0	\$816,565,089

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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EXPLANATION

This request is retroactive to September 1, 2019 in order to reallocate 1.5% of the capitation payments to ensure access to care for Medicaid beneficiaries and help provide financial stability for safety-net providers. Network providers' provision of access to Medicaid beneficiaries could decrease without consideration of the impact of COVID-19. The directed payments described herein are intended to help, in part, providers remain available to beneficiaries and ensure network adequacy under CMS regulations.

In addition, this amendment will address the CMS requirement to strike contract language that directs administration and funds previously appropriated for the Granite Advantage Health Care Program's (GAHCP) community engagement requirements administered through the managed care contracts. This is because Community engagement requirements have been vacated by the court.

Summary of Changes

DHHS therefore proposes to make the following changes to components of the capitation rates in order to fund the proposed directed payment funding pool:

1. Reduce service costs by 1.5% for all services to recognize the expected net impact of reductions in non-emergency and elective service costs due to the COVID-19 pandemic social distancing guidelines, increased COVID-19 treatment costs, the impact of waiving certain prior authorization requirements, and reduced population acuity due to projected enrollment increases related to the recession
 - a. The MCOs have agreed to continue their capitation arrangement with the community mental health centers (CMHCs) at current payment levels and waive any related maintenance of effort (MOE) provisions for state fiscal year (SFY) 2020.
2. Reduce the per member per month (PMPM) administrative allowance for all rate cells by 1.5% to recognize that significantly fewer MCM program members are enrolled in care management programs compared to the 15% expectation in the MCM contract.
3. Further reduce the administrative allowance for the GAHCP Non-Medically Frail population by \$0.45 PMPM to remove costs related to the GAHCP work and community engagement requirement. The related funding is repurposed for the directed payment pool.
4. Reduce the gain/loss margin to reflect the shifting of revenue from at-risk services to the new non-risk directed payments. The gain/loss margin still represents 1.5% of at-risk revenue.
5. Calculate the amount available for the new directed payment funding pool, which is approximately \$11.7 million assuming the original projected enrollment level (i.e., not incorporating likely enrollment growth resulting from the recession).
6. The original CMHC directed payment remains unchanged.
7. The PMPM premium tax allowance remains unchanged because the capitation rates by rate cell are unchanged after the reallocation by component.

Safety-net Provider Directed Payments

Pending CMS approval, DHHS will require each MCO to pay a percentage distribution and initial allocation for specific qualifying services provided by the six safety-net provider classes based on January 2019 to June 2019 MCO encounter payments as described in Table 1 below.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Table 1			
New Hampshire Department of Health and Human Services Medicaid Care Management Program Initial Allocation of Directed Payment Sub-Pools			
Safety-net Provider Class	Percentage Distribution of January to June 2019 MCO Payments for Selected Services Only	Approximate September 2019 to June 2020 Direct Payment (Total)¹	Approximate September 2019 to June 2020 Direct Payment (Monthly)¹
FQHCs and RHCs	32.0%	\$3,744,000	\$374,400
Critical Access Hospitals	29.8%	3,486,600	348,660
SUD Residential Treatment	16.8%	1,965,600	196,560
Home Health	4.9%	573,300	57,330
Private Duty Nursing	8.8%	1,029,600	102,960
Personal Care	7.7%	900,900	90,090
Total Pool	100.0%	\$11,700,000	\$1,170,000

¹ Approximate values of the direct payment pool are based on the initial enrollment projections in the January 14, 2020 rate setting report. Actual monthly pool funding will be determined by actual MCM program enrollment multiplied by the PMPM directed payment funding for each rate cell in the September 2019 to June 2020 MCM program capitation rates.

An identified portion of the actuarially sound per member per month capitation payment to the MCOs multiplied by the member months the plan is paid for the month will form a pool to be used every month to make percentage add-on payments to the defined safety-net provider classes. The pool will be 1.5% of the capitation payments made to the MCOs, or approximately \$12 million for the September 2019 to June 2020 contract year (depending on actual enrollment). DHHS will establish the percentage of the pool that will be allocated to a separate sub-pool for each of the six safety-net provider classes based on historical MCO payments to these providers.

At the end of the month, the amount in each sub-pool will be divided by the payments made by the MCOs to the defined safety-net provider class for qualifying services adjudicated in the month. This calculation will determine the amount of the uniform percentage add-on for the month. The additional payments will be sent to the safety-net providers in the following month. It is anticipated that payments will be made on the following schedule:

- May 2020 payment: based on September 2019 to March 2019 encounters
- June 2020 payment: based on April 2020 encounters
- July 2020 payment: based on May 2020 encounters
- August 2020 payment: based on June 2020 encounters

Every add-on payment will be directly tied to a qualifying paid encounter, and include the ability to tie each payment to a specific service provided to a specific beneficiary through the data consistent with the managed care rule. As warranted to account for changes in the provider environment, CMS has advised that DHHS may amend its directed payment request.

**His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 5 of 6**

Elements Supporting CMS Approval

The CMS requirement for a directed payment approval under the COVID-19 parameters is to require implementation of a risk corridor for the September 2019 through June 2020 contract period to address the uncertainty of future medical costs given the COVID-19 pandemic.

In addition, as recommended in CMS guidance documents, additional administrative changes include:

1. For the September 2019 to June 2020 contract year, DHHS shall waive the quality withhold provisions of the Agreement due to the impact of the COVID-19 pandemic.
2. For the May 1, 2020 to June 30, 2020 time period, DHHS shall modify the auto-assignment algorithm to incorporate equal auto-assignment among the three MCOs due to atypical enrollment increase.

Should the Governor and Executive Council not authorize this request beneficiary access and provider stability of safety-net providers will be at greater risk.

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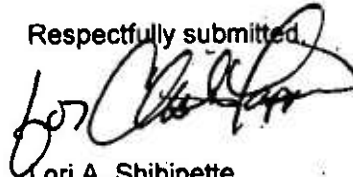
His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 6 of 6

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 93% federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 77.6% federal as appropriated by Congress and 22.4% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 22.7% General and 26.3% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, sums necessary to cover a projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,



Lori A. Shibinette
Commissioner

*The Department of Health and Human Services' Mission is to join communities and families
in providing opportunities for citizens to achieve health and independence.*

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

Jeffrey A. Meyers
Commissioner

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December 4, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Medicaid Services to retroactively amend existing agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schraffts City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, and by increasing the shared price limitation by \$18,750,925 from \$797,814,164 to an amount not to exceed \$816,565,089, in State Fiscal Year 2020, retroactive to September 1, 2019 with no change to the completion date of August 31, 2024, effective upon Governor and Executive Council approval.

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 77.6% Federal and 22.4% General; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 22.7% General and 26.3% Other funds.

This agreement was originally approved by the Governor and Executive Council on March 27, 2019 (Tabled Late Item A), and subsequently amended on April 17, 2019 (Item #9).

Funds are available in the following accounts for State Fiscal Year 2020 and are anticipated to be available in the State Fiscal Years 2021 through 2025, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

The Centers for Medicare and Medicaid Services (CMS) requires managed care rate certifications be completed on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each State Fiscal Year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how these contracts align with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for State Fiscal Year 2020.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$299,465,981	\$16,663,782	\$316,129,763
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD

Sub-Total \$299,465,981 \$16,663,782 \$316,129,763

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$54,818,300	\$229,586	\$55,047,886
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD

Sub-Total \$54,818,300 \$229,586 \$55,047,886

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC
MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
2020	101-500729	Medical Payments to Providers	\$443,529,883	\$1,857,557	\$445,387,440
2021	101-500729	Medical Payments to Providers	TBD		TBD
2022	101-500729	Medical Payments to Providers	TBD		TBD
2023	101-500729	Medical Payments to Providers	TBD		TBD
2024	101-500729	Medical Payments to Providers	TBD		TBD
2025	101-500729	Medical Payments to Providers	TBD		TBD

Sub-Total \$443,529,883 \$1,857,557 \$445,387,440

Grand Total	\$797,814,164	\$18,750,925	\$816,565,089

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
Page 3 of 5

EXPLANATION

This request is retroactive because of the delay in adopting a biennial budget and the need to update the capitated rates to reflect the various provisions of the budget that are incorporated into the Medicaid Care Management Program.

The amendment to the three (3) Medicaid Care Management (MCM) capitated and risk-based Agreements, including adjustments for September 2019 to June 2020 capitation rates for the MCOs and Exhibit A narrative contract changes, reflect the following changes:¹

Minimum Durable Medical Equipment (DME) fee schedule: Effective January 1, 2020, DHHS shall implement a minimum fee schedule DME services. The estimated impact of this change is approximately \$3.2 million over the January 2019 through June 2020 period.

Psychiatric boarding services: To improve continuity of care for mentally ill MCM members, DHHS shall fund psychiatric consultation services for individual in a psychiatric boarding situation. These services shall be effective March 1, 2020. The estimated impact of this change is approximately \$0.1 million over the March 2020 through June 2020 period.

Fee schedule updates: In accordance with annual CMS updates, reimbursement adjustments reflect the State Fiscal Year 2020 Federally Qualified Health Center (FQHC) encounter rates and the October 2019 (Diagnosis-Related Group) DRG rates.

Boston Children's Hospital (BCH) service funding: Funding for inpatient and outpatient BCH services shall reflect recent expenditure patterns prompting implementation of a risk pool in order to better allocate funds. As a result, claims incurred at the facility shall be excluded from stop-loss protections to avoid unintended interactions between the MCM Program's risk pool and stop-loss risk protection features. The estimated impact of this change is approximately \$1.4 million over the September 2019 through June 2020 period.

Non-Emergency Medical Transportation (NEMT) and Community Mental Health Center (CMHC) service costs: Increases in the Non-Medically Frail population's service costs for NEMT and CMHC costs for the January 2019 to June 2019 period warrant an increase to the base period data. The estimated impact of this change is approximately \$3.1 million over the September 2019 through June 2020 period.

MCO supplemental pharmacy rebates: Review of rebate eligible therapeutic classes revealed current spending did not support the preliminary 0.5% supplemental pharmacy rebate assumption; therefore, the rebate assumption is reduced from 0.5% to 0.1%.

Medically frail acuity adjustment: Review of emerging medical loss ratio (MLR) experience for the Medically Frail population indicated a likely difference in member health acuity between the base data period and emerging experience warrants adjustment to the base period data. The estimated impact of this change is approximately \$7.9 million over the September 2019 through June 2020 period.

Medicaid provider rate increases: House Bill 4, Section 348, of the 2019 NH Regular Legislative Session, directs increases to most Medicaid provider rates (excluding prescription drugs, designated receiving facility (DRF), and substance use disorder (SUD) residential treatment services), including State Plan Services and Waiver Programs by 3.1% effective

¹ Federal law requires managed care rates be reviewed no less frequently than a 12-month period. The Department aligns this process with the State Fiscal Year. The certified rate established for the program reflected in this contract is within the Department's budget for State Fiscal Year 2020. As in the past, the Department and Milliman will work with the legislature through the budget process to ensure the program is funded consistent with the budget.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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January 1, 2020, and an additional 3.1% effective January 1, 2021. The estimated impact of this change is approximately \$9.6 million over the January 2020 through June 2020 period.

Designated Receiving Facility (Involuntary) beds and rate increases: House Bill 4, Section 356, of the 2019 NH Regular Legislative Session, authorizes 8 to 10 new DRF beds, and increases the diagnosis related group (DRG) base rate reimbursement for all existing and newly established DRF beds when certain conditions are met. The new rates and additional beds are targeted for implementation on January 1, 2020. The estimated impact of the change is approximately \$2.2 million for the January 2020 through June 2020 period.

Mobile crisis team (MCT): Senate Bill 11, of the 2019 NH Regular Legislative Session, directs DHHS to create a new adult MCT to supplement those already in place. The new MCT is targeted for implementation on April 1, 2020. The estimated impact of this change is \$0.3 million over the April 2020 through June 2020 period.

The rate adjustments for all of the above program changes are for the ten month capitation rate period for Standard Medicaid and NH Granite Advantage Health Care Program for the September 2019 through June 2020 period with comparison to the previously approved rates are described in Table 1 below. The adjustment period is only 10 months because the prior contract was extended by two months to help effectuate the transition period for the new MCO and the new contract, which was approved by the Executive Council for a September 1, 2019 start date. The Department's actuary, Milliman, has certified a rate that is actuarially sound for this program.

Table 1
New Hampshire Department of Health and Human Services
Medicaid Care Management Program
September 2019 to June 2020 Capitation Rate Change
Based on Projected September 2019 to June 2020 MCO Enrollment by Rate Cell

Population	Original September 2019 to June 2020 Capitation Rate (March 4, 2019 Report)	Revised September 2019 to June 2020 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$316.28	\$325.85	3.0%
CHIP*	197.36	205.47	4.1%
Behavioral Health Population	1,387.60	1,435.06	3.4%
Total Standard Medicaid	\$390.19	\$402.67	3.2%
Granite Advantage Health Care Program			
Medically Frail	\$1,028.86	\$1,242.47	20.8%
Non-Medically Frail	486.09	475.18	-2.2%
Total GAHCP	\$590.15	\$622.28	5.4%
Total	\$446.21	\$464.19	4.0%

*The CHIP capitation rate is an average of the specific rate cells in which CHIP members are enrolled. We do not develop a CHIP specific capitation rate.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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In addition, Exhibit A narrative contract changes include:

1. Amendment #1 edits carried forward, with adjustments as needed.
2. Transitional housing program services and community residential services: Coverage for these supportive services has been adjusted to reflect a July 1, 2020 start date to correspond with related Request for Proposals activities.
3. Provider payment: Clarifications to provider payments are dependent upon New Hampshire Medicaid fee schedules.
4. Drug Utilization Review (DUR) program: Inclusion of contract provisions to address new federal compliance requirements for the MCM Program's DUR program.
5. Technical corrections: Technical corrections include edits to pharmacy encounter date submission timeframes.
6. Zolgensma: Addition of gene therapy medication, Zolgensma, as a drug covered by New Hampshire Medicaid effective September 1, 2019 due to its extremely high cost and low incidence rate, which makes cost for the treatment difficult to predict for inclusion in MCM capitation rates, including related risk protection processes.
7. Hepatitis C medications: With stabilization of treatment demand, Hepatitis C prescription drugs are carved into the program starting September 2019.
8. Downside risk mitigation: Inclusion of a downside risk mitigation process for the Granite Advantage Health Care Program (GAHCP) Medically Frail and Non-Medically Frail populations for the September 2019 through June 2020 period.
9. Local Care Management: The contract reflects a terminology change, "Local Care Management Network(s)", to better reflect the nature of the program's local care management model.

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 93% federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 77.6% federal as appropriated by Congress and 22.4% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 22.7% General and 26.3% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, sums necessary to cover a projected short-fall will be transferred from the liquor commission fund, established in RSA 176:16, as provided for by HB 4 Section 351, of the 2019 NH Regular Legislative Session.

Respectfully submitted,

for 
Jeffrey A. Moyers
Commissioner

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

Jeffrey A. Meyers
Commissioner

Henry D. Lipman
Director

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April 1, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services Office, to amend three (3) Agreements with AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schrafts City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, by changing the program start date from July 1, 2019 to September 1, 2019 to accommodate sufficient time for readiness activities needed to effectuate a well-executed implementation of health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, and by decreasing the price limitation by \$126,335,836 from \$924,150,000 to an amount not to exceed \$797,814,164 in State Fiscal Year 2020, for period September 1, 2019 through June 30, 2020, effective upon Governor and Executive Council approval, with a change to the completion date of August 31 2024, from June 30, 2024. The original Agreements were approved by Governor and Executive Council approval on March 27, 2019, Tabled Late Item A (Tabled by Governor and Executive Council on February 20, 2019).

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 78.8% Federal and 21.2% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 24.3% General and 24.7% Other funds.

Funds are anticipated to be available in the following account(s) for State Fiscal Years (SFY) 2020 through 2025 upon the availability and continued appropriation of funds in the future operating budgets. The Centers for Medicare and Medicaid Services (CMS) requires that managed care rate certifications must be done on no more than a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each state fiscal year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how this contract aligns with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for SFY 2020.

His Excellency, Governor Christopher T. Sununu
 and the Honorable Council
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**05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
 OFC MEDICAID SERVICES, GRANITE ADVANTAGE HEALTH PROGRAM TRUST FUND**

State Fiscal Year	Class / Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$360,150,000	(\$60,684,019)	\$299,465,981
SFY 2021	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$360,150,000	(\$60,684,019)	\$299,465,981

**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
 OFC MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/ Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$59,700,000	(\$4,881,700)	\$54,818,300
SFY 2021	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$59,700,000	(\$4,881,700)	\$54,818,300

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS:
OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/ Account	Class Title	Total Amount	Increase / (Decrease)	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$504,300,000	(\$60,770,117)	\$443,529,883
SFY 2021	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD		TBD
SFY 2025	101-500729	Medical Payments to Providers	TBD		TBD
<i>Sub-Total</i>			\$504,300,000	(\$60,770,117)	\$443,529,883

Grand Total	\$924,150,000	(\$126,335,836)	\$797,814,164
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EXPLANATION

The purpose of this request is to amend the three (3) Medicaid Care Management (MCM) capitated, and risk-based Agreements by changing the program start date from July 1, 2019 to September 1, 2019. The amendment is necessary to provide a sufficient readiness ramp up period for the Department and the Contractors known as the Managed Care Organizations (MCOs) so the health care services to 180,000 eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, are implemented smoothly, and by decreasing the price limitation by (\$126,335,836) from \$924,150,000 to an amount not to exceed \$797,814,164 in State Fiscal Year 2020, September 2019-June 2020.

The proposed change in program start date, to a later date, was necessary to provide Governor and Executive Council sufficient time to review the new contracts, hold two informational hearings, and to allow the Department and the MCOs the needed time for readiness to occur for the new Agreements. These three (3) MCOs will serve approximately 180,000 members including pregnant women, children, parents/caretakers, non-elderly, non-disabled adults under the age of 65, and individuals who are aged, blind or disabled, among others, as described in the Medicaid Care Management (MCM) contracts. The MCOs will cover the acute care, behavioral health, and pharmacy services for all Members and work with the Department to address the crucial social determinants of health in accordance with the attached MCM contracts.

The MCOs will provide a person-centered, integrated, and comprehensive delivery system that offers a very substantial array of accessible Medicaid services, taking into account each Member's physical well-being, behavioral health (mental health and substance use disorders), and social circumstances. The Department will challenge its MCO partners to work responsively with the provider community and MCM Members to improve access to care and promote healthy behaviors. New Hampshire's MCM program will incentivize value over volume, enhance program efficiency, and hold MCOs accountable for demonstrable improvements in health outcomes.

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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Table One represents a ten-month year capitation rate for the Standard Medicaid and the NH Granite Advantage Health Care Program for the period September 2019 through June 2020 with a comparison to the SFY 2020 rates in the February 15, 2019 signed contracts approved by the Governor and Executive Council of March 27, 2019 (Tabled, 2/20/2019 Late item #A). This allows alignment with State of New Hampshire fiscal year through SFY 2024. The change to the completion date of August 31 2024 is requested to allow for the full 60-month contract that was specified in the request for proposals.

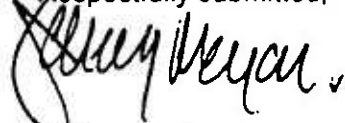
Table 1			
New Hampshire Department of Health and Human Services			
Medicaid Care Management Program			
Comparison of SFY 2020 to September 2019 to June 2020 Capitation Rates			
Based on Projected Enrollment by Rate Cell			
Population	SFY 2020 Capitation Rates	September 2019 to June 2020 Capitation Rates	Percentage Change
Standard Medicaid			
Base Population	\$315.15	\$316.28	0.4%
CHIP*	196.71	197.36	0.3%
Behavioral Health Population	1,386.51	1,387.60	0.1%
Total Standard Medicaid	\$389.03	\$390.19	0.3%
Granite Advantage Health Care Program			
Medically Frail	\$1,025.07	\$1,028.86	0.4%
Non-Medically Frail	482.80	486.09	0.7%
Total GAHCP	\$586.30	\$590.15	0.7%
Total	\$444.28	\$446.21	0.4%

*The CHIP capitation rate is an average of the specific rate cells in which CHIP members are enrolled. We do not develop a CHIP specific capitation rate.

Area served: Statewide. Source of Funds: Funds for Granite Advantage Health Program are 93% Federal as appropriated by Congress and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020 (as defined in RSA 126-AA:3, I); funds for the Child Health Insurance Program are 78.8% Federal as appropriated by Congress and 21.2% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 24.3% General and 24.7% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, consistent with RSA 126-AA:3, no state general funds shall be deposited into the fund and medical services for this population would end consistent with RSA 126-AA:3, VI and the terms and conditions of the federal waiver issued by the Centers for Medicare and Medicaid Services.

Respectfully submitted,



Jeffrey A. Meyers
Commissioner



Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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February 15, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to enter into Agreements with, AmeriHealth Caritas New Hampshire Inc., 200 Steven Drive, Philadelphia, PA 19113, Boston Medical Center Health Plan Inc., Schraffts City Center, 529 Main Street, Suite 500, Charlestown, MA 02129, and Granite State Health Plan Inc., 2 Executive Park Drive, Bedford NH, 03110, to provide health care services to eligible and enrolled Medicaid participants through New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management, in an amount, for State Fiscal Year 2020 shared by all vendors, not to exceed \$924,150,000, effective upon Governor and Executive Council approval, with providing services to members on July 1, 2019 through the completion date of June 30, 2024.

Funds for Granite Advantage Health Program are 93% Federal and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 79.4% Federal and 20.6% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal, 24.3% General and 24.7% Other funds.

Funds are anticipated to be available in the following account(s) for State Fiscal Years (SFY) 2020 through 2024 upon the availability and continued appropriation of funds in the future operating budgets. The Centers for Medicare and Medicaid Services (CMS) requires that managed care rate certifications must be done on a twelve-month rating period demonstrating actuarial soundness thereby necessitating annual rate reviews in order to determine amounts each state fiscal year and corresponding contract amendments. Rates will be updated annually and as necessary for changes in the program enacted by the legislature. A description of how this contract aligns with the state budget process is included in the explanation below. For these reasons, expenditures for the program are identified only for SFY 2020.

05-95-47-470010-2358 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: OFC MEDICAID SERVICES, GRANIT ADVANTAGE HEALTH PROGRAM
TRUST FUND

State Fiscal Year	Class / Account	Class Title	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$360,150,000
SFY 2021	101-500729	Medical Payments to Providers	TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD
		Sub-Total:	\$360,150,000

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
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**05-95-47-470010-7051 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: OFC MEDICAID SERVICES, CHILD HEALTH INSURANCE PROGRAM**

State Fiscal Year	Class/Account	Class Title	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$59,700,000
SFY 2021	101-500729	Medical Payments to Providers	TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD
Sub-Total:			\$59,700,000

**05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS
DEPT, HHS: OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT**

State Fiscal Year	Class/Account	Class Title	Total Amount
SFY 2020	101-500729	Medical Payments to Providers	\$504,300,000
SFY 2021	101-500729	Medical Payments to Providers	TBD
SFY 2022	101-500729	Medical Payments to Providers	TBD
SFY 2023	101-500729	Medical Payments to Providers	TBD
SFY 2024	101-500729	Medical Payments to Providers	TBD
Sub-Total:			\$504,300,000
Grand Total:			\$924,150,000

EXPLANATION

The purpose of this request is to enter into capitated, risk-based Agreements to provide acute care and other medical services to eligible and enrolled Medicaid participants New Hampshire's Medicaid managed care program known as New Hampshire Medicaid Care Management. ~~These three (3) Vendors will serve approximately 180,000 members including pregnant women, children, parents/caretakers, non-elderly, non-disabled adults under the age of 65, and individuals who are aged, blind or disabled, among others, as described in the Medicaid Care Management (MCM) contracts. The Managed Care Organizations (MCOs) will cover the acute care, behavioral health, and pharmacy services for all Members and work with the Department of Health and Human Services (DHHS) to address the crucial social determinants of health in accordance with the attached MCM contracts.~~

The MCO Vendors will provide a person-centered, integrated, and comprehensive delivery system that offers a very substantial array of accessible Medicaid services, taking into account each Member's physical well-being, behavioral health (mental health and substance use disorders), and social circumstances. DHHS will challenge its MCO partners to work responsively with the provider community and MCM Members to improve access to care and promote healthy behaviors. New Hampshire's MCM program will incentivize value over volume, enhance program efficiency, and hold MCOs accountable for demonstrable improvements in health outcomes.

Two of the Vendors, Boston Medical Center Health Plan Inc., and Granite State Health Plan Inc., are respectively otherwise known as Well Sense Health Plan, and New Hampshire Healthy Families. The Department presently contracts with both of these Vendors to provide New Hampshire's Medicaid Care Management program.

His Excellency, Governor Christopher T. Sununu,
and the Honorable Council
Page 3 of 6

I. Procurement Process

These contracts represent the culmination of the Department's first re-procurement of the MCM program since its commencement in December 2013. The Department's process for the development of the program reflected in the contracts and the contracts themselves represent a significant improvement over the prior procurement process and the program itself. The Department -- for the first time ever -- put out the Request for Proposals for public comment and held public information sessions in each of the Executive Council Districts last July in Concord, Keene, Manchester, Nashua, Littleton and Portsmouth before it was issued to potential respondents.

These three (3) Vendors were selected through a competitive bid process. A Request for Proposals RFP-2019-OMS-MANAG-02 was posted on the Department of Health and Human Services' web site from August 30, 2018 through October 31, 2018. A mandatory bidder's conference was held on September 7, 2018. In-person attendance at the Mandatory Bidder's Conference was a requirement to submit a proposal. The Department received four (4) proposals. The proposals were reviewed and scored by a team of individuals with program specific knowledge. The Bid Summary is attached.

II. Central Features of the New MCM Program

This procurement was also focused on improving the program for beneficiaries and providers and introducing many new features. The goals of the new MCM program are to

- Improve care of Members
- Improve health outcomes
- Reduce inpatient hospitalization and re-admissions
- Improve continuity of care across the full continuum of care
- Improve transition planning when care is completed
- Improve medication management
- Reduce unnecessary emergency services
- Decrease the total cost of care
- Increase member satisfaction
- Improve provider participation in the program

In order to help achieve these goals, the new contracts make many changes in the current program. These include the following:

- **Additional Care Coordination and Care Management** resources to provide significantly more beneficiary support to those in greater need, including providing it at a local level. MCOs must provide Care Management for at least 15% of high-risk/high-need members, and MCOs must conduct local care management or contract with a designated care management entity for at least 50% of high-risk/high-need members.
- **Behavioral Health (Mental Health and Substance Use Disorder) provisions** support integration of care with physical health, implementation of the Department's new 10-year Mental Health Plan, and advance SUD treatment. MCOs are required to take into account each person's physical health, behavioral health (mental health and substance use disorders), and social and economic needs. MCOs are required to work with Members, Providers, integrated delivery networks (IDNs), and community mental health

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programs (CMHPs) to integrate physical health and behavioral health and address social determinants of health that affect health outcomes and the cost-effectiveness of care.

- **Emergency Room Waiting Measures** include the provision of additional clinical staff to support the provision of services in hospital emergency departments to reduce the need for Members to wait for inpatient services.
- **Support the Community Mental Health Centers and Substance Use Disorder Providers** by entering into capitated payment arrangements with Community Mental Health Programs and Providers, and reimburse substance use disorder providers at rates no less than the DHHS fee-for-service rates. MCOs must also contract with any willing peer recovery provider.
- **Alternative Payment Models (APMs)** provisions require MCOs to incentivize value over volume and significantly reduce current fee for service billing arrangements.
- **Community Engagement** specifies a role for the MCOs to support beneficiaries in fulfilling the Community Engagement requirement, including assisting their members with understanding qualifying activities and exemptions.
- **New Provider Supports** require MCOs to implement prompt and accessible credentialing and re-credentialing processes that will be used to conduct provider outreach and support; standardize work processes to ensure efficient implementation of the program and minimal provider burden relative to claims billing processes, reporting, and prior authorizations; meet prompt payment requirements and pay claims based on the effective date of the Current Procedural Terminology code, and establish a provider grievance and appeals process.

- **Pharmacy Counseling and Management** are strengthened to help improve the safety and therapeutic benefits to beneficiaries and the economy of the program.
- **Beneficiary Choice and Competition** is increased by providing Medicaid beneficiaries with three high-quality MCOs from which to choose.

- **Incentives and opportunities for beneficiaries to participate in healthy behaviors** must be provided by MCOs to improve individual health.
- **Cost transparency** through reference based pricing and incentives to beneficiaries.
- **Accountability for results** is increasing because a share of payment to MCOs will be directly linked to their performance, ensuring accountability for results, particularly in high priority areas such as addressing substance use disorders, integrating physical and behavioral health, providing robust care management, and reducing unnecessary use of high-cost services.
- **Public Reporting** is an added contract element. Each selected MCO will be responsible for submitting an annual report to the Governor and the legislature reporting on how the MCO has addressed State priorities for the MCM Program, including those specified in RSA 126-AA and in other State statute, policies, and guidelines; what innovative programs it has established; how it is addressing social determinants of health of its members, and how it is improving the population health of the state and other key metrics of the program.
- **Heighten program compliance and integrity provisions** have been added that allow for liquidated damages to be applied to the MCOs around contractual performance; provisions that incent MCO performance around collections for third party liability and coordination of benefits; and general fraud waste and abuse.

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- **Medical Loss Ratio** is specified in the contract at a minimum amount of 85% that must be spent on service delivery to beneficiaries, any amount less is to be rebated back to the Program.

III. Rate-making and Budget

The Department's actuary, Milliman, has certified a rate that is actuarially sound for this program. These rates are reflected in Table 1 below:

Table 1 New Hampshire Department of Health and Human Services SFY 2020 Capitation Rate Change Based on Projected SFY 2020 MCO Enrollment by Rate Cell			
Population	January 2019 to June 2019 Capitation Rate	SFY 2020 Capitation Rate	Percentage Change
Standard Medicaid			
Base Population	\$303.54	\$315.15	3.8%
CHIP*	188.36	196.71	4.4%
Behavioral Health Population	1,294.03	1,386.51	7.1%
Total Standard Medicaid	\$371.26	\$389.03	4.8%
Granite Advantage Health Care Program			
Medically Frail	\$993.36	\$1,025.07	3.2%
Non-Medically Frail	423.21	482.80	14.1%
Total GAHCP	\$532.03	\$586.30	10.2%
Total	\$416.29	\$444.28	6.7%

*The CHIP capitation rate is an average of the specific rate cells in which CHIP members are enrolled. We do not develop a CHIP specific capitation rate.

Federal law requires that managed care rates be reviewed no less frequently than a 12-month period. The Department aligns this process with the state fiscal year. Over the last several years, the rates have been reviewed and an amendment made to the MCM contracts in May or June for the fiscal year beginning on July 1st. In order to maintain actuarial soundness, the rates are also required to be reviewed in the event of significant program changes. For example, while the Department established rates for FY 2019 last spring, the Department was required to refresh and update the rates when the Medicaid expansion program was brought back into managed care on January 1, 2019 – in the middle of the state fiscal year.

This year, there are items in both the Governor's budget and in other legislation now pending that, if and when enacted, would require Milliman to revise the rates. Specifically, there are proposals to (i) raise the rates paid to community based designated receiving facilities, (ii) add transitional housing for persons who can be discharged from New Hampshire Hospital; (iii) add mobile crisis teams or other behavioral health crisis services. All of these

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additional services will have to be incorporated into the capitated rates for the managed care program consistent with their effective dates.

As a result, the Department anticipates that following the end of the legislative session, Milliman will review all program changes and any other relevant information, and adjust the rates as necessary. The Department would expect to bring an amendment to the contract in the September or October time frame for this purpose.

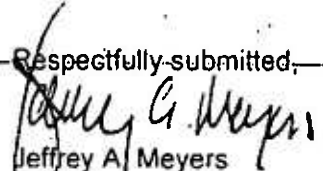
The certified rate established for the program that is reflected in this contract is within the Department's budget for state fiscal year 2020. Even though that the rates have been increased, a decline in the number of persons enrolled in Medicaid and a decline in the acuity of the population that has reduced expenditures in certain of the highest rate cells accounts for a reduction of total expenditure in the program within the current budget. As we have in the past, the Department and Milliman will work with the legislature in the budget process to ensure that the program is funded consistent with the budget.

Area served: Statewide.

Source of Funds: Funds for Granite Advantage Health Program are 93% Federal as appropriated by Congress and 7% Other for calendar year 2019 and 90% Federal and 10% Other for calendar year 2020; funds for the Child Health Insurance Program are 79.4% Federal as appropriated by Congress and 20.6% General funds; and funds for the standard Medicaid population funding under the Medicaid Care Management account are 51% Federal as appropriated by Congress, 24.3% General and 24.7% Other funds.

In the event that Federal funds become no longer available or are decreased below the 93% level for calendar year 2019 or 90% level for calendar year 2020, for the Granite Advantage Health Program, consistent with RSA 126-AA:3, no state general funds shall be deposited into the fund and medical services for this population would end consistent with RSA 126-AA:3, VI and the terms and conditions of the federal waiver issued by the Centers for Medicare and Medicaid Services

Respectfully submitted,


Jeffrey A. Meyers
Commissioner